Official Publication of the
MEDICAL AND CHIRURGICAL FACULTY
OF THE STATE OF MARYLAND

Maryland
STATE MEDICAL JOURNAL

9 NO. 6
E, 1960

SEMIANNUAL MEETING—FRIDAY, SEPTEMBER 16, 1960
COMMANDER HOTEL, OCEAN CITY, MARYLAND

FROM PARKE-DAVIS... A NEW ORAL ANTIBIOTIC WITH EFFECTIVE ANTIBACTERIAL & ANTIAMEBIC ACTIONS

"THE FORTUNATE COMBINATION OF HIGH ANTIAMEBIC AND ANTIBACTERIAL ACTIVITY AND LOW ORAL TOXICITY MAKES PAROMOMYCIN UNIQUE AMONG THE AVAILABLE DRUGS AND SUGGESTS THAT IT SHOULD BE A USEFUL THERAPEUTIC SUBSTANCE."[1]

● **IN INFECTIOUS DIARRHEAS[2-5]** Because it is effective against gram-negative pathogens, HUMATIN has proved especially valuable in infectious diarrheas, most of which are caused by bacilli of the gram-negative group. In 221 patients with severe diarrhea, 85 per cent obtained rapid remission of symptoms with HUMATIN, and stools cleared quickly of pathogens.[2] Results in *Shigella* and *Salmonella* enteritis,[5] and in infantile diarrheas of mixed etiology[3] have been uniformly good.

● **IN INTESTINAL AMEBIASIS[2,5-8]** HUMATIN is unusually effective in clearing all phases of intestinal amebiasis;[5] to date, more than 700 patients have been treated successfully with HUMATIN in all parts of the world. Since HUMATIN is not appreciably absorbed from the gastrointestinal tract it is not effective against extraintestinal forms of amebiasis.

Hum

MARYLAND
STATE MEDICAL JOURNAL
Volume 9 June 1960 Number 6

EDITORIAL

HAVE WE MISSED THE BOAT?

FIFTY YEARS AGO, in the golden days of medicine, medical men were the acknowledged leaders of the growing group of persons interested in the social sciences. Medicine today is still the best informed of the social sciences but is fast losing its dominant position among them. Why is this?

The whole Edwardian era was pervaded by an optimistic atmosphere of progress. It included a world-wide spread from Europe of that idea that each man is born equal in the sight of God and has an inalienable right to an equal chance to develop his potential. This was a fruitful atmosphere for such proponents of improvement as medical men. Medicine was first in the field. It had developed many of the early concepts which led to improvement in the general, as distinct from individual, welfare. It has developed the concept of hygient, of public health, of common sewers and drains, of campaigns against malaria and yellow fever. Medical men led the social sciences because medicine was the social science with a dynamic concept and with knowledge. The general populace was willing to be led—although there was strong opposition—because the evident skill, knowledge, and dynamism of the doctors produced confidence.

Unfortunately the medical profession is still proposing the same panaceas for the world's ills as it did in 1910. The world meanwhile has moved on to more pressing matters. It is easy to "sell" the public on campaigns for fluoridation, inoculations, or funds for research. In some cases the public is too easily convinced. Most persons maturing in the past 40 years have had the value of such projects drilled into them with the 3 R's. The great medical men of the turn of the century led the public to unqualified acceptance of hygiene. The comparable "public health" problem of our generation is the provision of adequate medical care for the whole population. Here the public, following other leaders has decided that they must and will have 100 per cent medical coverage for the people, with protection from financial disaster by the insurance method. The medical profession, instead of grasping an early opportunity to carry the ball towards such a desirable goal, waited too long and now is reduced to running interference for the ball carrier.

Any action to alter this state of affairs must of course have the consent of a majority of the profession. The elected representatives of the medical profession

Reprinted from The Canadian Medical Association Journal, 74:299, February 15, 1956. Thanks to I. Ridgeway Trimble, M.D., for submitting to the Maryland State Medical Journal.

in their various organizations at provincial or national level cannot go further or faster than their constituents wish. Delay in development of physician-sponsored prepaid medical-care plans reflects reluctance of certain physicians to concern themselves with this social problem.

Most practitioners today have more knowledge of the science of medicine than Osler, but not many can be expected to have the skill to lead the public to a new era. There are two components to leadership, as historian Arnold Toynbee and others have so skillfully pointed out: first, the natural right of leadership which is synonymous with knowledge or skill in one's own field; and second, a willingness to be led by the potential follower—the lay public. There is no inherited right to lead. In fact, Toynbee shows decisively that when leadership by skill is replaced by leadership by tradition, and when following by choice is replaced by compulsion, a society (whatever social grouping is under discussion) is ipso facto dying. The result is always eventual emergence of a new social grouping based on new leaders whom the public will follow.

The medical profession is losing its dominance of the social sciences on all counts. It is losing the natural right of leadership because it is tending to become a conservative self-restrictive profession instead of a widely based social science constantly broadening its scope. It is thereby losing the skill required to lead society. Society itself is finding the leadership of medicine irksome because medicine no longer talks the language the public wants to hear. Society is interested in the social and economic aspects of medicine. Doctors tend to withdraw from such strange things into the safety of 17-ketosteroid estimations.

To paraphrase Professor Hatch of the University of Pittsburgh (who spoke of engineers), "perhaps the objective of medical educators should be to broaden medicine rather than to 'liberalize' the physician." How very wise those pioneers have been proven who started schools of social medicine at their universities. Certainly they often talk nonsense, but so did Hippocrates, Avicenna, Pasteur, and Freud. If our profession wants to lead the social development of our society, it must obtain the knowledge to do so. It must draw the social sciences around itself by dynamic leadership of them.

An anchorite in his cave or a monk in his monastery may be dedicated, but not to the common weal. He can have no effect on current events except the negative effect induced by the absence of his counsel. If medicine wants to withdraw into itself and become an esoteric and specialized science, such as atomic physics, the profession will become a follower of public opinion, not its architect; an employee of the public, not a servant of the people.

L. F. KOYL, M.D.

RESOLUTIONS . . . .

Medical and Chirurgical Faculty

All resolutions to be presented to the House of Delegates at its meeting on Friday, September 16, 1960, *must* be in the Faculty Office, 1211 Cathedral Street, Baltimore 1, *no later* than Friday, July 22, 1960.

New Faculty Officers

Whitmer B. Firor, M.D.

WHITMER B. FIROR, M.D., Baltimore radiologist, became president of the Medical and Chirurgical Faculty of Maryland on April 22, when retiring president, Leslie E. Daugherty, M.D., of Cumberland, presented to him the traditional inscribed gavel.

Taking office as vice presidents were Edmond J. McDonnell, M.D., Baltimore; Merrill M. Cross, M.D., Silver Spring; and Harold B. Plummer, M.D., Preston. William Carl Ebeling, M.D., Baltimore, and Wetherbee Fort, M.D., Baltimore, continue as secretary and treasurer, respectively. New members of the Council are M. McKendree Boyer, M.D., Damascus; Everett S. Diggs, M.D., Baltimore; Edward W. Ditto, Jr., M.D., Hagerstown; and W. Royce Hodges, Jr., M.D., Cumberland.

Doctor Firor holds degrees from The Johns Hopkins University and The Johns Hopkins University Medical School. He has practiced radiology in Baltimore since 1930 and is chief of radiology at Union Memorial, Women's, and Sheppard-Pratt hospitals, as well as radiologist at Children's Hospital.

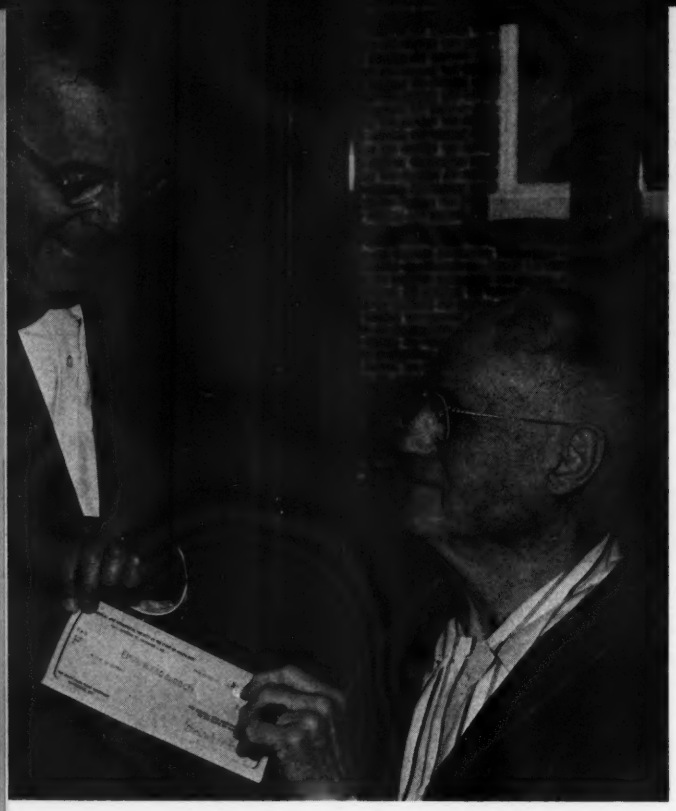
He was in the Medical Corps of the United States Army, as a colonel, from 1942-1946, during which time he served in Australia, New Guinea, Philippine Islands, and the United States.

Doctor Firor has written a number of articles on his specialty and was associate editor of the Year Book of Radiology from 1932 to 1947. He is a past president (1958) of the Baltimore City Medical Society, a member of the American Roentgen Ray Society, and a Fellow in the American College of Radiology.

Doctor Firor, at present, is assistant professor of radiology at The Johns Hopkins University School of Medicine, having received this appointment in 1951, after serving as an instructor for many years. He is also a member of the Medical Board for Occupational Diseases of the Workmen's Compensation Commission for the State of Maryland.

Married in 1928 to Mildred Isabelle Conley, Doctor Firor has one son, Whitmer B. Firor, Jr., M.D., who is assistant resident in surgery at the University of Toronto, Ontario, Canada.

Non-professionally Doctor Firor belongs to the Maryland Club and the Elkridge Club and enjoys music and literature as his hobbies. The Firors' residence is at 4400 Norwood Road, Baltimore.



WALTER N. KIRKMAN MADE HONORARY MEMBER IN FACULTY AND PRESENTED WITH CHECK

WALTER N. KIRKMAN, who recently retired after 13 years of service to the Medical and Chirurgical Faculty of Maryland, became the second layman in Faculty history to be granted honorary membership with privileges for life. This action was unanimously approved by the House of Delegates at its opening session on April 20.

As a further token of appreciation, he was given a check, presented on behalf of the Faculty by Treasurer Wetherbee Fort, M.D. The actual presentation took place at Union Memorial Hospital, where Mr. Kirkman was convalescing from a broken hip; however, the official ceremony was enacted at the April 20 meeting of the House of Delegates.

DR. FORT: Mr. President and members of the House of Delegates, today I have a very pleasant duty to perform, which is in contrast to my usual one of screaming for more money and, at the same time, being quite a pinch-penny with what money we have. After all the wonderful praise and tributes which I am sure Dr. Goldstein will say about Mr. Kirkman tomorrow night at the banquet, when he will present Mr. Kirkman with a scroll, you might wonder what more could be said. Believe me, there still is a lot; and I could talk at great length about Walter and what this exacting financial wizard has done for the Medical and Chirurgical Faculty of Maryland.

His gentle, mild manner and completely placid temper have helped me over many rough spots. When I was pushing for assessment, which I'm sure no one in this room has forgotten, Walter would always back me up with facts and logic to calm the troubled waters, no matter where in the state the storms arose. The same was true with the pension plan, which has been placed in operation this year and which I believe to be completely satisfactory to all our loyal employees.

A more humble man I never knew. At first he was the commander-in-chief, working with no official title as executive secretary, but still running the show. When our first executive secretary came in, Mr. Kirkman very graciously stepped down, never failing, however, to help the gentleman in every way possible. He did the same when Mr. Sargeant came to us a year and a half ago, and I know Mr. Sargeant would be the first to say "hallelujah" to this.

These few examples are from a long list. I would like to tell you how valuable I considered his service to me during the past six years. Be assured, Walter, you have a special place in the hearts of everyone in this room tonight. Someone can take your place, we know, as, in time, someone will for all of us. But you, Walter Kirkman, can never be replaced.

One final remark, I feel, will be of great interest to all: only twice in the history of this great organization has a layman been made honorary member, with all the rights and privileges to attend meetings and festivities without charge. He told me who the first man was, but I've forgotten; and the second, of course, is our Walter Kirkman.

It is my privilege and sincere pleasure to present you with this little check from the Medical and Chirurgical Faculty of Maryland as a small token of our appreciation for your loyal and faithful service through the years. God bless you, and may you enjoy many years of health and happiness.

MAKE YOUR PLANS

to attend

THE OCEAN CITY MEETING

of the

Medical and Chirurgical Faculty

(Semiannual Meeting)

FRIDAY, SEPTEMBER 16, 1960

CIRCLE THE DATE ON YOUR CALENDAR *NOW!*

Scientific and Business Sessions, Choice of Indoor or Beach Luncheon, Dance.
Watch for your program.

HEADQUARTERS • COMMANDER HOTEL

HOTEL RESERVATIONS

Make your room reservations *now* by writing DIRECTLY to Commander Hotel. For your convenience, detach the following and mail to:

Commander Hotel

Mrs. John B. Lynch, Ocean City, Maryland

Name .....

Address ..... City ..... State .....

Please Reserve..... Room *Approximate Rate.....

Date of Arrival ..... Date of Departure .....

No. of Persons .....

All Requests Subject to Confirmation

*Family Rates: $7.25 to $12.00 per person. (Sept. 6 to Sept. 26) Ocean front rooms available.

Panel Discussion

MYOCARDIAL INFARCTION

versus

GALL BLADDER DISEASE

Panel Members

E. Cowles Andrus, M.D., Moderator

George G. Finney, M.D.

Louis Krause, M.D.

DR. ANDRUS: This is to be an unrehearsed presentation. Dr. Finney, Dr. Krause, and I gathered for lunch the other day, and we decided that we would make this a sort of dialogue or trialogue, rather than any formal presentation. I shall, from time to time, ask questions of my colleagues and I suspect they will do the same to me. We want to leave time at the end of our discussion, indeed we will interrupt our discussion at any time, to answer questions from the floor.

I am going to start out by asking Dr. Krause why we should suppose that there is any connection between the gall bladder and myocardium, or the diseased myocardium, or coronary disease.

DR. KRAUSE: That is a good question, because, if you notice, the title says "Myocardial Infarction versus Gall Bladder Disease." You'd think they wouldn't occur together, but they do. They are rarely separate as indicated by the title. One must remember the confusing picture that may be presented, bearing in mind the gall bladder and its nerve supply. The gall bladder has a distinct nerve supply that comes from the sympathetic or the splanchnics by way of the celiac plexus, which follows the cystic artery up to the gall bladder itself. In addition, the vagus, the right vagus particularly, has fibers that go to the gall bladder.

Presented at the 159th Annual Meeting of the Medical and Chirurgical Faculty of Maryland, May 1, 1957.

It is believed that the branches of the vagus carry inhibitory and motor fibers to the gall bladder. That is as much as we know, but bear in mind there are other things in the gall bladder and in those ducts that are related to the nervous system. There are little tiny plexuses located along the length of the gall bladder. They are tiny and comparable to Auerbach's plexus in the gastrointestinal tract. No one knows whether they are motor or inhibitory, sensory or not. They are mediated to some extent through the vagus, so one can have some reflex reference to the chest very readily. This nerve supply arises from the cord from the sixth thoracic down to the first lumbar. This explains why one may have referred pain to the back, on the right side, or even to the right shoulder. It may be on the other side, too.

The problem in making the diagnosis of gall bladder disease is because of the pattern of pain produced.

DR. ANDRUS: Thank you, Dr. Krause. Dr. Finney, have you the impression that more of your patients who come to surgery for gall bladder disease have some coronary disease than do those with other abdominal conditions which you are called upon to operate?

DR. FINNEY: I think we are all more aware of this possibility. It has been mentioned that more individuals over 40 years of age who have gall bladder disease also have some evidence of either hypertension or of coronary disease. This is not only true in men, where I believe you will agree there is more coronary disease, but in women as well. This possibility gives rise to the question from the surgical standpoint, as we see such a patient, whether the diagnosis is clear or whether we are dealing with a situation where there is mimicry. There may be both coronary disease and gall bladder disease. An observation made as long ago as 1924 by Dr. Blalock and recently by Dr. Warren Cole and his associates in Chicago, was that in 15 per cent of the patients who showed symptoms that apparently were caused by gall bladder disease, the pain was more prominent on the left side than it was on the right.

DR. ANDRUS: We are gradually building up a body of confusion which I hope we can do something to elucidate. I want to add to what Dr. Krause has said about the reasons for the association or the interaction of these two processes and recall to your mind the studies of Gilbert and Fenn, in Chicago, who showed that at least in animals, experimental distention of the gall bladder or the gall duct by balloon caused changes in the electrocardiograms in the direction consistent with myocardial ischemia. Those were normal animals. Dr. Stroud, who preceded us on this program, reported a number of years ago (I just asked him, and he said he has not added to that report) instances of patients with gall bladder disease with abnormal electrocardiograms in which the electrocardiogram reverted toward the normal after removal of the diseased gall bladder. Now, how would you make the differential diagnosis between gall bladder and myocardial disease?

DR. KRAUSE: I have no illusions about making a diagnosis of anything in a 100 per cent fashion. I do want to emphasize, however—and my practice is essentially bedside medicine—that the man who is in the best position to make a diagnosis of gall bladder disease is the man who first sees the patient and who takes the time to listen carefully to his story. When you have an outstanding finding in an EKG or a gall bladder so distended you feel the hydrops, then you don't have to have diagnostic acumen. I want to emphasize that point because I think listening to the history cannot be overemphasized. The reference you made to the distended gall bladder with the balloon within it reaffirms what has been known for a long time. Heberden mentions that the first thing you get is pain referred to the midline. It isn't always classically over the gall bladder in the early stages. More frequently it is in the midline, but not for long, a few hours or maybe half a day. If the distention continues, the pain becomes localized over the gall bladder. An occasional coronary starts that way, too. Nevertheless, one is more apt to find referred pain to the midline in the earliest stages of biliary disease. As the distention increases, localization develops directly over the gall bladder or in the right shoulder or the back. May I leave the thought that the history is the most important thing in the early stages of gall bladder disease.

DR. ANDRUS: I would like to underscore that for coronary disease. Certainly nothing has been invented that is so useful in such a large proportion of instances in the diagnosis of cardiac pain than is an unhurried, deliberate, and carefully guided interview with the patient. Dr. Finney, do you want to add to the diagnostic criteria or procedure?

DR. FINNEY: I don't believe I can add anything specifically to the diagnostic criteria, but I would like to underscore what Dr. Krause has said. Some things are impressed on us rather definitely. Sometimes we see a patient who has a pretty typical picture of what we think is gall bladder disease. X-rays of the gall bladder taken on two or three occasions show that it fills with dye and empties quite normally, and, therefore, as far as we can tell, there is normal function. I have operated on three patients within the last 18 months where this was true. I believed in the internist who had seen these patients and had gone over their histories carefully. At the time of the operation, I could not definitely feel stones in the gall bladder;

nevertheless, I removed the gall bladder. There were small, soft calculi stuck against the wall of the gall bladder in each patient.

We know that if a gall bladder that is not definitely diseased or contains no stones is removed, the patient may continue to have symptoms; therefore, we surgeons must be extremely careful before deciding to go ahead with cholecystectomy. There must be evidence of calculi and trouble with the gall bladder before we consider removing it.

DR. ANDRUS: Thank you, Dr. Finney. Dr. Krause, one reason that the problem has always been confusing to me, and I suspect that the one reason for the subject's being on the program today, is that there is a considerable overlapping in the area of distribution of pain or discomfort in coronary disease with that of gall bladder disease. Do you have any guiding principles or suggestions in that direction?

DR. KRAUSE: I don't believe I do. The continental investigators or observers always stress the fact of inframammary pain and supramammary pain on the left side. Inframammary pain is seldom due to coronary disease. In this country, however, a fair percentage (at least a third) of patients with coronary disease may begin with pain below the nipple line on the left side, so that is no help at all. I am more influenced by the fact that there is a greater incidence of pain on the left side, particularly if the patient is a man. In a woman, the chance of its being gall bladder disease is much greater than it would be in a man. The amount of shock and the appearance of the patient give an impression of how severe it is. I have seen shock in coronary disease far more frequently and far more distressing than in biliary disease. You have seen patients rolling in pain and doubling up, but they are not in shock. I think the overall picture plus the fact that the pain is more apt to be on the right side in biliary disease and on the left side in coronary disease are the determining factors.

DR. ANDRUS: Do you think that other manifestations from the gastrointestinal tract are more common with biliary disease than with coronary disease?

DR. KRAUSE: That is a point to be debated. The frequency with which patients want to belch or have sensations of gas in the upper gastrointestinal tract is a little more frequent in biliary disease; although I have seen it also in coronary disease. I am thinking of a doctor in this Faculty, whom we all loved and knew, who had a coronary thrombosis. His chief complaint, the same as I have heard in others, was "If I could only pass some gas." He had increased peristaltic action apparently, or just had the sensation of it; yet he had a full blown coronary and died because of that particular attack.

DR. ANDRUS: Thank you. I must say, speaking for myself, that there is little or no assistance which I can gain from the other gastrointestinal symptoms which accompany either one of these conditions. The patient with angina pectoris sometimes belches impressively and frequently as his pain abates after taking nitroglycerin. Did you ever see the pain of gall bladder disease relieved by nitroglycerin?

DR. KRAUSE: Not dramatically. I usually resort to morphine or demerol or something like that.

DR. ANDRUS: Have you used it?

DR. KRAUSE: No I have not.

DR. ANDRUS: Since you have mentioned drugs, do you prefer morphine in gall bladder disease?

DR. KRAUSE: I try the lesser ones first, but I usually wind up using morphine.

DR. ANDRUS: With a severe pain I think so, too.

DR. FINNEY: Could I bring up something here? We have thought from the surgical standpoint that unless we gave enough morphia to knock the patient out, his pain might be intensified by giving morphia. I think Dr. Ravdin did some experiments which indicated that unless knockout doses were given, there would be spasm of the sphincter of Oddi and distension of the duct with increased pain. So, I'd like to know specifically what dose of morphia you would give and whether something like Pantopon® or demerol might, in general, work better.

DR. ANDRUS: Assuming that we are dealing with acute cholecystitis or with stones, small doses of morphine are spectacularly useless. I should think 15 milligrams, repeated if necessary, would be the least that could be expected to be useful. As far as coronary pain is concerned, I prefer to avoid morphine. I have the impression that it augments the tendency to vomit and complicates the picture. I prefer to use demerol or Pantapon®. Dr. Krause, do you want to comment?

DR. KRAUSE: I feel the same way. I am aware that the opiates contract the second portion of the duodenum and are apt to make a patient vomit. In a gall bladder attack, I start out with 15 milligrams of morphine. If it doesn't give relief quickly (half an hour or so) and the patient seems to be in excruciating pain, I repeat the dose.

DR. ANDRUS: I think we might proceed to the differential diagnosis and the possible application of some of the newer laboratory studies. We have quite properly laid special emphasis on the history, and I repeat that there is no device which is 100 per cent certain. The sedimentation rate may be elevated in any of these acute reactions. The transaminase is likely to be up when hepatic disease accompanies gall bladder disease. Perhaps some of the profiles of enzymes which are being developed may be useful, but they are not in the state, at present, to be practical except as investigative tools. Dr. Finney, do you think all patients with gall bladder disease, say gallstones, ought to be operated on?

DR. FINNEY: The percentage that should not be operated on is small. Warren Cole of Chicago once said he thought something less than 30 per cent of all individuals with gallstones had symptoms from them. I think that estimate is low and I'd like to know what you think. You cannot arbitrarily say that all should be operated on. There are many complications from what at first might have been termed silent gallstones, which add to the morbidity and the mortality.

DR. ANDRUS: Dr. Finney, you talk about the complications of gall bladder disease. Are there any complications from gall bladder surgery?

DR. FINNEY: There certainly are, and these should be measured against the good that will result from operative procedures. The former Dr. Lahey of Boston, when he reported so many cases of reconstruction of the common duct, used to say, partly facetiously, that he had two or three areas from which most of these cases were referred. I am sure no surgeon is looking for that type of case. There are injuries to the common duct and other complications that can occur at the time of the operation, and, therefore, it is important that each gall bladder operation be performed carefully by the surgeon. There is evidence to make us think that in uncomplicated cases of cholecystectomy, the mortality rate should be less than 1 per cent, nearer 0.5 per cent. Most patients are well afterwards, which doesn't mean that sometimes there aren't troubles afterwards; because we know there are.

DR. ANDRUS: Dr. Krause, what is your opinion about how gall bladder disease, including stones, once identified, should be treated?

DR. KRAUSE: I'm afraid the medical treatment leaves a lot to be desired. There is a lot of folklore about a diet for a gall bladder patient. What is the best stimulant for the gall bladder that we know? It's fat. What does the radiologist use to demonstrate the contraction of the gall bladder? It's fat, but how often are attacks precipitated in the x-ray room? Many patients are unaware of the presence of a gallstone until their discovery by x-ray. When questioned, the patients report that they have been able to eat everything; nothing bothers them. Once you tell them about gallstones, somebody is going to tell them, "Oh, yes, you've got to leave out fat from your diet." Ask other patients what they eat. "Oh, I avoid this kind of fat and that kind of fat."

"Do you take dessert?"

"Oh, yes, I take dessert."

"What do you take for dessert?"

"Well, apple pie and ice cream." There's an excellent source of fat; yet the patients have little discomfort.

I don't know of any effective means to correct gall bladder disease or stones by medicine. Once I have diagnosed gall bladder disease with stones, I recommend surgery.

DR. ANDRUS: Dr. Finney, do you have any in-

hibitions about operating for gall bladder disease in the presence of what your medical colleagues call coronary disease?

DR. FINNEY: We used to feel more hesitation than we do now, but it certainly makes us think twice. With the help of our medical colleagues, particularly our good anesthesiologists, the increase in either postoperative morbidity or mortality is insignificant compared with many of the striking changes that take place in the patient after removal of a gall bladder with stones. This is as true in patients who have had definite coronary symptoms as in those who have had what were believed to be just gall bladder symptoms.

DR. ANDRUS: What should be the time interval between a myocardial infarct and removal of the gall bladder, assuming that definite attacks of both have occurred, with gall bladder attacks occurring two or three times a year. My own guess would be to put it off for six months if I could, assuming a sizable infarct; however, if it had to be done within three months, I think it could be. Dr. Krause, do you want to comment?

DR. KRAUSE: I feel the same way about it. These coronaries do very well with surgery after a given length of time.

DR. ANDRUS: Any comments, Dr. Finney?

DR. FINNEY: No sir, except that I certainly agree with your feelings on that point.

Q. If the patient with myocardial infarction is in severe shock, the absorption of morphia given subcutaneously is unpredictable. What is the panel's feeling about giving the drug intravenously in such cases?

DR. ANDRUS: Another route which may be utilized, beside the subcutaneous, is the sublingual route. Morphia can be absorbed from under the tongue if the tablet is fresh. I haven't hesitated, on rare occasions, to give very small doses of morphine intravenously to patients with a myocardial infarct.

Q. Please discuss the use of atropine with morphine sulphate to prevent nausea when treating acute gall bladder colic.

DR. KRAUSE: I usually give atropine with morphine together in one tablet. Don't forget that you can get nausea and vomiting from morphine even though atropine is with it.

Q. Dr. Finney, would you operate upon a supposedly normal gall bladder after you have repeated EKG studies and gall bladder visualization? The patient is complaining of typical gall bladder attacks. Do you still think in terms of small, soft, non-radiopaque gall stones?

DR. FINNEY: That's when I rely on the good judgment of an internist. I try to go over the history carefully; for I am convinced that if there is a good history which seems airtight and nothing else that can be proven, such as a hiatus hernia or peptic ulcer, the patient deserves an exploration. There are symptoms that are called psychoneuroses, and to distinguish them we have to depend a lot on the makeup of our patient. I hope we surgeons will be less and less guilty of removing a gall bladder without sufficient reason for doing so. If there is any question about the diagnosis, I think a period of observation should be pursued.

DR. KRAUSE: May I add some additional things about this. You are going to see some patients who have pain, which seems like gall bladder. You have exhausted every mode of investigation, or think you have, but be sure to include good studies of the vertebra and the ribs. That brings to mind one patient. A gentleman here in the audience who was with me at Walter Reed and I stumped our toes on a nurse patient who had repeated gall bladder complaints. Nothing was demonstrated. She left the hospital and went to a civilian hospital to seek surgery and relief, but she returned for study, and finally x-ray demonstrated an hemangioma in the body of a vertebra, which gave referred pain to the front of the abdomen. Surgery gave immediate relief.

Be as comprehensive as possible in your investigation, and, as Dr. Finney mentioned about the hiatal hernia, look for the arthritis, the myeloma, and the benign lesions, such as hemangiomas.

Q. A female patient, age 46, had her gall bladder removed. She still has gall bladder signs and symptoms. The electrocardiogram shows evidence of coronary disease. Do you regard the coronary disease as significant?

DR. ANDRUS: If the gall bladder is removed, where does she get her symptoms and signs of gall bladder disease. Dr. Finney?

DR. FINNEY: I can't answer specifically, but I can cite one of my own cases, which happened to be a woman, 47 years of age and quite stout. She also had some hypertension. She had a typical picture of recurrent coronary attacks and she had a gall bladder full of gallstones. I did a cholecystectomy on her, and she was relieved of her attacks of dyspepsia and gas for about a year. She subsequently died, and an autopsy showed a coronary occlusion.

Q. How frequently does angina pectoris benefit from removal of a stone-bearing gall bladder?

DR. ANDRUS: Probably rarely, but certainly occasionally, and sometimes dramatically. Since I, for one, am limited in my ability to cure angina pectoris, if the removal of a gall bladder containing stones has any good chance of affording relief, I would be a party to its removal. How about you, Dr. Krause?

DR. KRAUSE: Yes, I have sponsored that several times because I had nothing else to offer the patient.

9 East Chase Street
Baltimore 2, Maryland
(Dr. Andrus)

2947 St. Paul Street
Baltimore 18, Maryland
(Dr. Finney)

11 East Chase Street
Baltimore 2, Maryland
(Dr. Krause)

SUPERVOLTAGE RADIOTHERAPY AN

IN THE MANAGEMENT OF

FRACTURES OF LO

PATHOLOGICAL FRACTURE of a long bone is not a common occurrence in the management of terminal cancer, but when it does occur the attending physician is often overcome by a feeling of hopelessness and despair. Such a feeling is unwarranted when adequate therapy is undertaken; for approximately 15 per cent of such cases will survive for at least one year (1) from the time of the fracture. Fitts (2) and his group at the Hospital of the University of Pennsylvania advocate energetic treatment for these fractures.

The primary sources of malignancy to bones are breast, lung, kidney, and thyroid, in that order. The purpose of this paper is to outline an energetic course of therapy which will enable the unfortunate individuals to survive in comfort for a greater length of time.

Peltier (3) points out that the object of treatment is to relieve pain and restore function as soon as possible. Time is of the essence if life expectancy is short; therefore an energetic treatment is preferred to prolonged immobilization. Treatment should be a combination of surgical internal fixation and radiotherapy. Fractures of the femoral neck or intertrochanteric region of the femur are secured by the use of a Smith-Peterson or Jewett nail, or replacement arthroplasty is done. A fracture of the middle third of the femur or of the humerus should be held in place by an intramedullary nail of some type.

Peltier (4) has shown that tumor cells can be spread within the marrow cavity by passage of an intramedullary nail, so radiotherapeutically, the guiding principle must be to treat over the lesion and the entire length of the fixation device rather than direct irradiation to only the visible area of bone destruction.

Technically, pathological fractures need the same emergency treatment as any other fracture. Surgically, it is preferable to expose the shaft and pass the intramedullary nail with direct visual control; otherwise, it is easy to cause false passages, and the adjacent tissues are often stiff, preventing an easy rotation of the fragments. One may get a hematogenous spread of tumor cells when inserting an intramedullary nail, but as this is already a blood-borne metastatic process, such a consideration loses much of its importance. Tumor cells may be forced down the medullary canal by the fixation device, but this is alleviated by radiotherapy over the entire length of the nail. Lastly, an open reduction may give some soft tissue dis-

A plea is made for the energetic treatment of pathological fractures in long bones. A plan of therapy using a combination of surgical internal fixation and radiotherapy is presented.

AND INTRAMEDULLARY FIXATION

OF PATHOLOGICAL

LONG BONES

semination. At operation, a biopsy is taken at the fracture site for the histological picture to aid in assessing radiotherapy.

Radiation is begun early, even before the sutures are removed. We have never had any problem in delay of wound healing. Radiation treatment consists of about 3,000 roentgens delivered through multiple ports to the tumor in two weeks for an undifferentiated tumor. If the intramedullary device is used, the entire long bone is irradiated. Bremmer and Jelliffe (1) have shown that supervoltage obviates the differential absorption of the metallic pin.

Since the disease is rather rare, there is not a large series of statistical followups for evaluation; nonetheless, in patients surviving longer than six weeks, about 75 per cent go on to bony union in lesions of the femoral shaft (1). From the standpoint of morbidity, most patients continue to walk on crutches. No rigorous course of physical therapy can be given such as in an ordinary traumatic injury.

The handling of incipient fractures demands the prophylactic use of this technique. It is much easier to use an internal fixation device while the bone continuity is still present and blind insertion is possible. A big advantage to this fixation technique is the marked relief of pain. The nursing difficulties are eased, and the patient can lie freely in bed without weights or a heavy cast, and soon he can be up in a walker or on crutches. From a radiotherapeutic standpoint, the technical aspect of delivery of dosage is much easier.

Without operation and using irradiation and immobilization only, the limb should be immobilized for three to four weeks for a primary myeloma, since the lifespan is short; whereas six to eight weeks immobilization is satisfactory for a hormone-dependent deposit. If the latter has been demonstrated, chemotherapy should be instituted simultaneously.

Department of Radiotherapy
Presbyterian Hospital
Charlotte, North Carolina

REFERENCES

1. Bremmer, R. A. and Jelliffe, A. M.: J. Bone & Joint Surg. **40-B**:652, 1958.
2. Fitts, W. T., Jr., Roberts, B., Ravdin, I. S.: Am. J. Surg. **85**:282, 1953.
3. Peltier, L. F.: Minnesota Med. **40**:799, 1957.
4. Peltier, L. F.: Surgery **29**:466, 1951.

O. Ralph Roth, M.D.

Inflammatory Edema and Capillary Hemorrhage

Wallace Marshall, M.D.

Many diversified human diseases carry an edematous component which is caused by inflammation or trauma. The edema itself is produced by a marked dilatatory state of the microcirculation, which causes increased venous pressure and increased capillary permeability. A most logical therapeutic approach is based upon the constriction (and, therefore, the correction) of these dilated vessels. The author has been able to obtain more than adequate therapeutic response with Kutapressin†, a satisfactory microcirculatory constrictor, which apparently adequately controls both capillary hemorrhage and inflammatory edema; these are closely related etiologically.

A NOVEL METHOD for teaching various aspects of clinical medicine might be through the use of riddles or conundrums. Here is an example: What do the allergies, acute prostatitic inflammations, infections, and other tissue inflammations have in common? The obvious answer is *tissue swelling*. All of these clinical entities show various grades of tissue swellings, which, in turn, are produced by tissue edemas. Inflammatory edema is a particular form which accompanies infection, trauma, or a combination of both etiologic factors.

One of the first observations a clinician witnesses when a patient has been traumatized by infection or physical force is the presence of tissue swelling. A blow to the eye region produces a pronounced puffiness of this facial area; the discoloration comes later. The first measure most persons take to reduce the swelling is to apply an ice bag; or they might treat the swelling by wrapping a raw steak around the involved area, having the misguided idea that the meat will draw out the swelling. The use of an ice bag possesses more merit because it, at least, is physiologically sound; the cold decongests the inflamed tissue by slowing down the increased blood supply to the injured area.

But what produces this tissue swelling primarily? Again, the involved area has experienced some form of trauma. The injury might have been caused by thermal agents, as those which are produced by a severe burn; or the trauma might have been caused by bacterial infection, which caused the inflammatory tissue response. Another common type of tissue swelling is caused by an insect sting (formic acid); or a patient could readily obtain an untoward tissue swelling response by sitting in a poison ivy patch—the television and radio reports as to the value of a current oral poison ivy preventive preparation notwithstanding! A friendly wifely swat to a husband's smirking visage can produce the telltale facial swelling which is subsequently reported to have been caused by a swinging door. The cold knife blade approach usually follows to reduce the evidence of such an untimely encounter.

Any form of trauma, as exemplified by such a

†Kutapressin® is manufactured by the Kremers-Urban Company, 141 West Vine Street, Milwaukee 1, Wis.

blow, can produce tissue swelling, but, unfortunately, it is not explained that easily; nor are all the scientific answers presently known to explain such a common episode. By the time all the smoke has cleared sufficiently, several important events have taken place in the traumatized area which are most worthy of further examination and explanation.

The traumatizing factor, be it a lowly bee sting or the intense heat from boiling water or oil, has, by its force, released certain pathologic chemicals in the injured tissue area. These substances produce a final marked dilatation of the microcirculatory blood supply to that area. The capillary permeability of the walls of these tiny vascular containers now allows the fluid contents to leave these vessels, the newly released fluid invades the adjacent tissue spaces, and tissue swelling takes place (1). Furthermore, venous pressure increases markedly, which event further increases the venous congestion in the involved area. This occurrence further tends to increase the presence and the scope of the tissue swelling. If on or near the surface of the body, this traumatized area can be seen to "puff up."

Now, let us examine these events as they occur in some of the common diseases, for these findings are observed daily in any physician's practice.

The Skin Allergies

It seems to me that lately many more patients exhibit various and more allergic disturbances than were discovered, say, 20 years ago. Patients now consult their physicians for reactions to the sulfa drugs, for procaine reactions, for reactions to tetanus antitoxin (horse serum), and for untoward penicillin reactions. The cause for such increase is that the patients are building up states of hypersensitivity to these foreign substances, perhaps because of their unlimited and untimely use for nonessential maladies, as for treatment of colds and the like.

One of the first symptoms such patients experience with these atopic reactions is generalized itching, perhaps because of the formation of a generalized dermal edema which irritates the skin nerve endings and thus produces itching, which is the precursor of pain stimulation. If the untoward allergic response progresses, the patient will note the rapid formation of skin wheals (hives) which itch intensely. If these are not adequately treated, an edema of the patient's glottis may occur, in which case, a pen-knife tracheostomy must be performed to enable the unfortunate patient to breathe.

This constitutes a striking example of tissue swelling (edema) produced by an atopic reaction (2).

The Hemorrhage Response

It might come as a shock to my readers to regard bleeding as being associated with those responses which accompany edema formation. But, considering that some of the events which produce edema are caused by fluid leaving the minute blood vessels in a traumatized area by means of diapedesis, then it can be seen that the relationship between fluid loss and its escape from the vessels is really a form of edema formation. With frank hemorrhage (rhexis) the continuity of these vessels' walls has been interrupted and the fluids escaping from these minute vessels invade the surrounding tissue because of the holes (large or small) in the vessel walls. What difference does it really make whether or not these vessels lose their blood because of rhexis or diapedesis? The results are the same, pathophysiologically speaking (3), and it would be well to bear this logic in mind, particularly when therapy is discussed.

The Diarrheal Response (Flux Formation)

It has been demonstrated repeatedly that inflammation of the gut walls takes place as a forerunner to the formation of diarrhea. In such an event, some alimentary toxin or toxins have produced gut inflammation, which is followed by a marked vascular dilatation of the vessels of the gut walls. The familiar edema-response is then set into motion, and the dilated gut vessels (intestinal microcirculation) spill their escaping fluid into the very thin gut walls. The close proximity of the alimentary lumen allows this vascular fluid to become siphoned out, and the fluid is forced into the intestinal lumen, thereby forming the diarrheal flux. Again, I ask that my readers bear these pathophysiologic events in mind when the newer therapy for diarrheal flux is discussed (4).

Fibroid and Keloid Formations

I have shown previously that edematous fluid invasion of normal tissue, if not removed presently, causes a chemotaxic response which produces an invasion with fibroblasts and a consequent piling up of such tissue. For example, when a wrestler or a pugilist suffers a severe blow to the parenchymatous tissue of his ears, an invasion of edematous fluid occurs in these damaged auricular tissues. If not removed reasonably soon, fibroblasts begin to invade this traumatized area, thus producing the well-known "cauliflower ears." During my college days, every participant in these sports was taken immediately to the University dispensary, where the edematous fluid was withdrawn with a needle and hypodermic syringe. This simple therapeutic procedure eliminated the later formation of the disfiguring aural lesions which are commonly known as "cauliflower ears." To my knowledge (I recently had the opportunity of discussing the above procedure with a university wrestling coach), cauliflower ears have never occurred in wrestlers who have submitted to this procedure.

Some years ago, I had many opportunities to test the aforementioned procedure in reverse; for I repeatedly injected certain circumscribed small thigh areas on myself with serum taken from myself and serum obtained from other patients. Control areas on the opposite thigh received normal saline solution. No growths occurred. But in those thigh areas which received the multiple blood serum injections, when these areas (plus the control areas) were extirpated by myself under local anesthesia, the tissue specimens showed definite early keloidal growths (5).

Injecting the uteri of virgin dogs with their blood serum, with the hope of producing uterine fibroids, was not successful. It was discovered later that dogs are not, as a rule, subject to fibroids. Lack of funds prevented my repeating the same procedure on virgin monkeys. When one recalls the crampings and squeezings which accompany all the menstrual cycles every female endures, it is no wonder that the trauma of birth might force some of the blood serum into the uterine walls and thus cause the subsequent growth of fibroids (6). It would be highly interesting if a research-minded surgical colleague would try the above experiments in suitable animals to try to produce uterine fibroids from inspissated blood serum.

Pulmonary Fibrosis and Retrolental Fibroplasia

Let us now give some consideration to two lesser known diseases which may well exhibit similar pathophysiologic aspects. Interstitial pulmonary fibrosis perhaps contains a tissue allergy background. One of the first tissue responses to injury in this disease is the exudation of serous fluid, which invades the lung. One of the main causes for this marked serous exudation (edema) is the presence of the markedly dilated capillaries. The inspissated serum, as was the case with early keloidal growth, cannot escape, and it exerts a chemotaxic response which attracts fibroblastic infiltration, which attacks the alveolar walls, and deposits collagen and reticulin.

To summarize: an allergenic response produces capillary dilatation; the blood serum leaves the capillary vessels and invades the alveolar walls, and a fibroblastic invasion follows. So we can note the marked similarity which exists between each of these separate diseases. The basic pathophysiologic similarity is the insult to viable tissues, which is followed by capillary dilatation and invasion of the edematous transudate, which, in turn, sets off a fibroblastic tissue invasion and the subsequent replacement of normal, functioning tissue with fibrous tissue (7).

Retrolental fibroplasia is an involvement of the retinal blood vessels which later become detached, causing subsequent loss of vision. This disease is thought to be produced by high oxygen concentrations. Later, the retinal vessels become markedly dilated, and a serous exudation (edema) is produced, which process is followed by a retinal fibroplasia and loss of vision. Here again is met the aforementioned cycle; namely, tissue injury (caused, in this case, by excessively high oxygen concentrations), which produces retinal vessel dilatation, then excessive edema formation, and then the influx of fibroblasts (8).

Acute Benign Prostatic Hypertrophy

The last disease entity which will be examined, but by no means the only other comparable patho-

physiologically produced disease with a comparable etiology, is the acute form of benign prostatic hypertrophy. Numerous other diseases show similar disease cycles which can be triggered by a dilated microcirculation; however, this prostatic type of disease is described here because it lies in an entirely different part of the human body.

It has been demonstrated repeatedly that bacterial infections and other forms of trauma produce a markedly dilated microcirculation in patients with the acute form of benign prostatism. This marked dilatation of these prostatic vessels allows the blood serum to escape and invade the glandular parenchyma; hence, the acute forms of this disease always contain an edematous component. If left undisturbed and untreated, a marked fibroblastic influx follows, which tends to replace the edema with fibroblastic overgrowth; thus, this pathophysiologic cycle has many points of similarity with keloidal growth elsewhere in the body (9).

The chronic forms of prostatitis have lost the edematous component, and these glands have become fibrosed markedly.

All the various diseases which we have discussed, plus many, many more diseases which we have not mentioned, exhibit diseased microcirculations, exemplified by the presence of marked dilatation of the tissues' microcirculation. Edema is formed because of the subsequent escape of the blood fluid which invades the adjacent tissues. Unless the clinician removes the inspissated edematous fluid, a fibroblastic invasion ensues, which invades the erstwhile normally functioning tissues, causing scar tissue or even a piling up, due to the formation of excessive fibrous tissue infiltrations.

The clinician will do well to remember always the adverse role which can be played by the presence of edema formation produced because of microcirculatory dilatation (10). Therefore, whenever the question arises as to whether or not to rid the involved area of the invading edema, the answer invariably must be a resounding YES, and the sooner the better.

Specific Therapy for the Removal of Tissue Edema

The hypothesis presented did not evolve overnight, but came as a result of more than 20 years of hard work, and it appears that it will take another 20 years to persuade my medical confreres to drop their current views on edema formation in favor of this new approach.

The data were unfolded as I began treating successfully with a single medication patients with acne vulgaris, then keloids, and finally numerous other disorders. Many colleagues inquired how one medication could give adequate therapeutic results in so many diversified cases. The answer becomes quite understandable when one recalls that all these diseases exhibit microcirculatory dilatations, a marked edematous component, and fibrosis if the patient is not adequately treated. A successful medication must exert its pharmacologic effect upon one or another of the pathologic dilated vascular components, which is exactly what the medicament used does. It constricts the dilated microcirculatory vessels and thus prevents further edema formation and eventual fibrous tissue invasion. We have plenty of drugs which constrict the dilated systemic vessels, but to my knowledge, no other material is now known which is limited to a specific microcirculatory constricting action. This knowledge is of recent origin and is the result of many clinical studies which were performed by myself and my various research colleagues.

By correcting the omnipresent microcirculatory dilatation which allows the formation of transudatory edema of inflammatory nature, we prevent its occurrence. In so doing, we prevent, furthermore, the resulting sequelae, such as the edematous exudates which follow gall bladder surgery, the lochias which follow the trauma connected with childbirth, and even the hematogenous exudates which produce epitaxic episodes, as well as a host of other exudatory phenomena. Since prevention is the best form of therapy, by vasoconstricting the microcirculatory components of inflamed tissues, we thus prevent these various and lesser understood exudatory signs which can accompany many diseases (11).

Kutapressin,® the Microcirculatory Constrictor

The substance is derived from crude liver by a series of selective extractions and concentrations,

which remove much of the thick, nonpharmacologically active substances. Among the toxic ingredients removed are the materials which both increase and decrease systemic blood pressure; so the purified product (Kutapressin®) exerts no known ill effects upon the systemic blood pressure. The final product is non-allergenic, and it shows practically no minimal lethal dosage of clinical importance; as a matter of fact, an entire ampule (10 cc.) of Kutapressin® can be administered subcutaneously at one time without any known danger, since it has no known contraindications.

The usual dose is two cubic centimeters, given subcutaneously in an uninvolved arm area. If a patient has a marked or a generalized or a particularly large edematous area, five cubic centimeters can be administered initially with comfort to the recipient. This dose can be repeated as indicated or desired, since it absorbs readily and it is not painful upon administration.

A few clinical examples may help my readers to better understand the use of this medication. A three-year-old boy, weighing only 20 pounds, was brought to the office. Malnutrition was obviously present, with the usual accompanying rachitic signs. This child had passed 12 blood stools that day, and he was markedly dehydrated. But what brought this child to us was the rectal prolapse; the rectum protruded about six inches. The child had just been released from an osteopathic hospital, where the physician had manually replaced the rectal prolapse every time it herniated.

The child was immediately given two cubic centimeters of Kutapressin® subcutaneously, and the diarrhea, which was rapidly causing the marked dehydration, stopped completely upon administration of this injection. The child was hospitalized promptly, and subcutaneous fluids were administered. He received what most physicians would consider a massive dose of Vitamin D—10,000 units per day. Within a week's time, the child had gained eight pounds, his bowel movements became normal, and the erstwhile rectal prolapse reduced itself. The boy has continued to gain weight and remained well.

Since he was seen, I had a similar case in which the rectal prolapse again corrected itself with the strengthening of the child's rectal musculature. As with the first child, the diarrheal flux was terminated immediately by the use of Kutapressin®, because the markedly dilated gut microcirculation became vasoconstricted, thus preventing further exudative responses and, therefore, preventing further diarrheal flux.

A few days before this writing, an adult male patient reported stacking a hay bundle which contained poison ivy. When I saw him, his penis and its foreskin exhibited a marked phimosis and paraphimosis. Because of the action of the highly toxic urushiol which the poison ivy contained, the microcirculatory vessels of the involved penile areas had become noticeably dilated, and edematous involvement ensued, producing phimosis and paraphimosis with marked weeping.

Five cubic centimeters of Kutapressin® were administered subcutaneously in the arm, whereupon the severely involved areas began to lose their edematous infiltrations. The patient was hospitalized and two hours later received a repeat dose of Kutapressin® (5 cc.). Within six hours after I first saw this patient, his penile areas were normal, and he was discharged from the hospital on the day after his admission. Kutapressin® had been employed to constrict the dilated penile microcirculation, which was the source of the edematous invasion in the involved areas.

The rationale behind this new therapy is simple to understand, when one has the facts concerned with these disorders.

The described therapeutic procedure should be confined to patients who have edemas of inflammatory origin. Kutapressin® will not be effective in patients who have edemas of heart, kidney, or other areas if inflammation is not the essential factor.

It has been previously mentioned that this preparation has been used adequately to stop capillary types of hemorrhage, particularly in patients who have had tonsillectomy.

Another male patient, 63 years of age, complained of bleeding from his penile orifice. I received the following report from his Board urologist:

> *Mr. X has had a prostatic resection and has quite a tendency to bleed from inflammatory polypi, which developed in and around the prostatic bed. In March, 1958 he was brought to me as an emergency with a bladder full of blood clots. I then cleared the bladder clots and electrocoagulated the bleeding areas. He got along very well all summer, but was*

in the office in November, 1958 and stated that he had again some hematuria. At the time of the office examination the urine was free of blood but showed considerable pus and I prescribed Terramycin®. If the bleeding is not profuse, treatment of the infection might suffice. If it is profuse an indwelling catheter for a few days should prove beneficial. He does not have cancer.

I did not employ a catheter, although the patient continued to bleed profusely; but he was given the above antibiotic, which rapidly cleared the urinary infection. He also received daily Kutapressin® injections in an arm area (2 cc.), and within 24 hours, the hemorrhage stopped. He went for three days without further therapy, then he began again to hemorrhage from the penile orifice. He again was given a Kutapressin® injection, and within 12 hours the bleeding stopped. Now, whenever he notices the onset of bleeding, he reports for therapy, and the Kutapressin® injection controls the bleeding from three to eight days. He has been able to build up and maintain his blood count adequately, and he has not missed a day's work since receiving the Kutapressin® control for his bleeding inflammatory polypi.

What has this form of therapy done to control such hemorrhage? We succeed, apparently, in vasoconstricting the markedly dilated microcirculatory components of these polypi with Kutapressin®. I believe that properly constricted capillary vessels will not hemorrhage (via diapedesis, which is strikingly similar to the pathogenesis of an inflammatory edematous transudate). There is no reason to hemorrhage, because the *capillary permeability* of these vessels is *not increased, nor is venous pressure increased.* On the other hand, when these same blood vessels become dilated, then both the capillary permeability and venous pressure become greatly increased, thus inviting diapedesis to recur.

Recently, a lad of five was run down by an automobile. The only pathologic finding noted upon examination (followed by extensive x-ray studies) was a hemorrhage from the right ear canal. This area continued to bleed until 15 minutes after the administration of two cubic centimeters of Kutapressin®. The hemorrhage has never recurred. The bleeding seemed to be a capillary type of oozing, similar to the oozing which is noted upon surgery of the abdomen. Apparently, the vasoconstricting effect from this preparation adequately stopped the further oozing of blood from the ear canal.

Whenever a capillary form of oozing of blood occurs anywhere in the body, it has been our practice for several years to administer immediately Kutapressin® therapy to control hemorrhage. Naturally, if a sizable blood vessel is cut, it must be tied and transfixed immediately; but the capillary type of bleeding usually responds rapidly and adequately to vasoconstriction with the use of Kutapressin®.

Another youngster, age nine, was struck by a car, and the only pathologic finding was blood, which was found upon repeated spinal taps. The patient received Kutapressin® in two cubic centimeter doses every four hours. The bloody spinal fluid cleared, and the child made an uneventful recovery within a week after injury.

No hypothesis is worth its salt if its therapeutic applications do not give the clinician and his patients adequate therapeutic results. Although I could continue extolling the value of this new therapy, few colleagues would be impressed; for the best method of allowing oneself to become "sold" on a new idea or procedure is to try it, not just on one patient, but on at least a half dozen or more suitable patients. After doing so, if you do not obtain suitable results, then write and inform me that a terrible mistake has been made; but at least try my suggestions. After all, you might be pleasantly surprised; for, as the old adage has it:

The proof of the pudding is in the eating thereof!

Madison at North Fourth Streets
Watertown, Wisconsin

REFERENCES

1. Moseley, H. F.: Textbook of Surgery, ed. 3, St. Louis, C. V. Mosby Co., 1959. See chapter on Inflammation and Repair.
2. James, F. and Marshall, W.: South Dakota J. Med. & Pharm. **11**:46, 1958.
3. Marshall, W. et al.: Ariz. Med. **13**:393, 1956.
4. Marshall, W.: Mississippi Doctor **37**:71, 1959.
5. Marshall, W.: Am. J. Surg. **69**:338, 1945.
6. Marshall, W. et al.: Am. J. Surg. **72**:57, 1945.
7. Read, J.: Am. Rev. Tuberc. **78**:353, 1958.
8. Paterson, D. and McCreary, J. F.: Pediatrics, Philadelphia, J. B. Lippincott Co., 1956, p. 498.
9. Ficarra, B. J. and Marshall W.: Brit. J. Clin. Pract. **12**:646, 1958.
10. Marshall, W.: Mississippi Valley M.J. **79**:202, 1957.
11. Marshall, W.: J. Inst. Homeo. **51**:97, 1958; **54**:38, 1960.

A gynecologist's own views on catheterization, intravenous therapy, early ambulation, and relief of abdominal distention after gynecological surgery.

POSTOPERATIVE GYNECOLOGICAL CARE

Leo Brady, M.D.

I HAVE NO INTENTION, in this discussion, of completely covering the subject of postoperative care of gynecological patients; rather, I shall dwell on just a few phases of it. First I shall consider the measures which, in my opinion, are most apt to bring about early voiding and thus lessen the incidence of urinary infection. Some of these measures are begun during the operative procedure and do not strictly belong in a discussion of postoperative treatment, but still they may be mentioned here. I refer to gentleness in handling of the bladder and ureters during the gynecological operation and the avoidance of trauma to these structures.

It is desirable to have a catheter in the bladder during all major abdominal gynecological procedures, for it keeps the bladder collapsed and, hence, lessens the danger of its being injured. At the end of the operation, I believe that the catheter should be removed, and I rarely leave one in, no matter whether the procedure was an abdominal or a vaginal one. Exceptions to this practice are operations for vesico-vaginal fistula, radical procedures with gland removal, and Marshall-Marchetti operations. Many of my colleagues disagree with my views on indwelling catheters and leave them in for days or a week after a vaginal hysterectomy or any plastic vaginal procedure and sometimes, even after abdominal operations.

I am not trying to prove the best procedure, but am merely outlining a routine which has worked satisfactorily for me. It might be argued that, as I do not extend the use of the vaginal hysterectomy as far as many of my colleagues do and, therefore, do not perform as many, I should be expected to encounter fewer urinary difficulties. Nevertheless, I do still perform many uterine interpositions, a procedure thought by some to be especially prone to cause bladder complications (which contention, incidentally, I do not agree with).

At the end of the operation, before the catheter is removed, 30 cc. of silver nitrate in a strength 1:1000 are instilled into the bladder. This produces a little chemical irritation which causes the bladder to contract and possibly hastens early voiding. Silver nitrate also has some prophylactic value in preventing cystitis. When the patient leaves the operating room, an order is left for her to be catheterized whenever she is uncomfortable. No regime of catheterizing every six or eight hours is followed. The bladder may be greatly overdistended in four hours, or in even less time, if the patient has been given large quantities of intravenous fluid during the operation; on the other hand, if she has received a small amount of fluid and has postoperative nausea, catheterization at the end of eight hours may yield very little.

During the operation, the anesthetist decides how much intravenous fluid the patient receives; but on the following morning, I put into effect measures based on my strong conviction that, in many cases, too much intravenous fluid is given and for too long. I see the patient myself on the morning after the operation and note whether or not she is nauseated and whether or not she has taken any fluid by mouth. If she has no nausea but still has taken no fluid, I tell her that unless

she takes by mouth a definite quantity in a definite time she will have to submit to intravenous therapy. A patient, unless she is feeling quite ill, will make an effort to drink water or some other fluid to avoid "needles in the vein." Often if the surgeon himself pours out the water and hands it to the patient, she will drink it, even though she has steadily refused to swallow a drop for the nurses. This response is not due to any charm or eloquence on the part of the surgeon; the patient is merely trying to follow the directions of the one to whom she has entrusted her life.

What is the necessary minimum amount of daily fluid intake necessary and minimum urinary output? Some authorities say that 3000 cc. is the minimum intake for 24 hours and 800 cc. the minimum urinary output. These are good yardsticks to remember, but I believe that if the surgeon evaluates each patient individually, adjustments can be made to these standards. Even if the patient has taken no fluid for several hours or since early evening, when intravenous fluids are terminated, as long as she is not vomiting and agrees to try to drink, I instruct the nurses to hold off intravenous fluids for several hours, hoping that in the meantime the patient will start to take fluids by mouth. In many cases she will do so.

In many hospitals, it is routine for house officers to leave orders for two intravenous injections of 1500 cc. to be given on the day after operation. This lessens the necessity of the house officer's checking on each patient to determine whether she needs intravenous therapy early in the morning before he goes to assist in the operating room. Many gynecologists apparently have no objections to the routine practice of giving intravenous therapy to their patients on the day after operation, maintaining that to do so guarantees that they will not be dehydrated. Although appreciating the danger of patients' becoming dehydrated, I am convinced that if the attending surgeon personally checks his patient early in the morning after surgery, he can avoid unnecessary intravenous therapy.

I believe in limiting intravenous therapy to the minimum which is safe. Giving fluids by vein causes the patient discomfort. Anyone who has been operated on—and I have had three operations—knows how unpleasant it is to have one's arm strapped to a board for a long period of time and how severe is the pain when the fluids get out of the vein, as occasionally happens in all hospitals. There are more important disadvantages to unnecessary intravenous therapy than the discomfort it causes. In older people with limited cardiac reserve, there is the possibility of overloading the vascular system. Then, too, while fluid is being given, it is impossible to get the patient out of bed; and, in my opinion, nothing is so valuable as early ambulation in getting the patient to void.

Early ambulation is of value, not only because it makes it easier for the patient to void, but also because it helps overcome abdominal distention. Indeed, it lifts the patient's morale, for she realizes that her doctor does not consider her critically ill if he allows her to get out of bed. Although I am enthusiastic about early ambulation, I realize that it carries some dangers which should be guarded against. One patient of mine, who had been aroused from her bed on the day after operation and left sitting in a chair by the nurse, fainted and was for some time in a condition of shock. I do not leave a routine order for the patient to get out of bed on the day after operation, but I wait until I can see her on my morning rounds. I have her sit on the side of the bed, keep my finger on her pulse, and ask her how she feels and whether or not she is dizzy. If she develops no symptoms and shows no signs, I have her take a dozen steps. The nurses are instructed to repeat this short walk several times a day, but they are not to leave her sitting in a chair until her second day after the operation. Actually, sitting in a chair accomplishes little more than sitting up in bed.

Thanks to improved anesthesia, fewer patients suffer from postoperative abdominal distention than they did 30 years ago. Then it was almost the rule. In gynecological patients, distention is usually either limited to the lower half of the abdomen or it involves the entire abdomen; however, occasionally, it is especially most marked in the epigastrium, and when this is so, it usually means that the stomach is dilated.

In dealing with this complication, a simple procedure is often of great help: turn the patient on her face. It is of little use to leave an order for a nurse to see that this is done. It is usually necessary for the surgeon or house officer to supervise and often to actually help. The

patient with a markedly distended stomach is extremely uncomfortable and does not want to be touched, much less moved. To accomplish it, first of all, take her pillows away and have the bed absolutely flat, then have the patient herself turn slowly over. Of course, she will complain about lying on her incision, but once she has turned all the way over and stops trying to support herself on her arms, she usually relaxes and is glad to remain in this position for some time. Having her back rubbed while she is on her face is usually welcomed.

To prove that the measures I have described lessen the incidence of complications and make the patient's postoperative course less unpleasant would require observations on a large series of patients and comparison of the results obtained with those in a similar series in which they were ignored. However, hoping to find some statistical basis for my ideas about postoperative treatment, I have studied the postoperative course of 100 consecutive patients on whom I performed major gynecological surgery. Not included in my study were three Marshall-Marchetti operations and three panhysterectomies with gland dissection for carcinoma. I omitted these six patients because I used retention catheters in them; in none of the 100 on whom these studies were based were retention catheters used. I was especially interested in learning two things: First, how many patients had to be catheterized, and, if catheterization was necessary, how often did it have to be repeated until they were able to void satisfactorily? Second, how many patients in this series received intravenous fluid on the second postoperative day.

Sixty-eight of my 100 consecutively performed major gynecological operations were carried out through the abdomen, and 32 through the vagina. Without listing in detail each operative procedure, I will mention that the abdominal group included 53 panhysterectomies, while in the vaginal group there were 14 modified Manchester, two vaginal hysterectomies, seven Watkins interposition operations, and three operations for large enteroceles.

The fact that a patient has to be catheterized once or twice after major surgery usually means no more than that during the first 24 hours when she was too groggy to void in a recumbent position. Only when a patient needs to be catheterized four or more times do I admit that she could be said to have real urinary retention.

Considering all of the 100 cases together, including both abdominal and vaginal, 33 did not need a single catheterization; they voided within eight hours after the operation. Twenty-four had to be catheterized only once, 22 twice, and 15 three times; six needed four or more catheterizations. Of these six who, in my opinion, might be considered to have real urinary difficulty, three had had an abdominal operation and three a vaginal operation. Of the patients in the latter group, one had a vaginal hysterectomy, one a Watkins Interposition operation, and one an operation for a large enterocele. Of these six patients needing four or more catheterizations, two voided before a fifth catheterization was necessary, two after six catheterizations, and the remaining two after seven catheterizations. It was not necessary to use tidal drainage on any patient. In several of the group in which four or more catheterizations were carried out, a few bottles of beer seemed to bring about the desired result, although the beer may have had a psychological effect rather than a scientific one.

I had the impression that very few of my patients received intravenous therapy after the day of operation, and the figure obtained by checking these 100 cases showed the number to be even lower than I had anticipated; only two of the 100 received any intravenous fluid on the day after operation.

The excellent care given my patients by the Department of Anesthesia at the Hospital for the Women of Maryland, where all these patients were operated on, played a significant part in bringing about the results I have enumerated. The anesthesiologists have the responsibility, not only for the actual anesthetic, but also for the selection of the sedatives and anti-emetics given during the first 24 hours after operation.

Even allowing considerable credit to the Department of Anesthesia, I am convinced that the measures I have emphasized (and I mean emphasized, because none of them are original with me) have been at least partially responsible for the small number of patients needing catheterization and for so few patients to require intravenous fluids after the day of operation.

Medical Arts Building
Baltimore 1, Maryland

A case presentation and discussion of the clinical syndrome of true

MEGALOBLASTIC ANEMIA OF PREGNANCY

Irving Kuperman, M.D.

MEGALOBLASTIC ANEMIA of pregnancy is one of the several severe anemias which may occur during the pregnant state or the puerperium. Osler[1] first drew attention to this clinical entity in 1919, when he noted a remarkable spontaneous remission after delivery in patients thought to have pernicious anemia.

In the tropics, megaloblastic anemia associated with pregnancy has attracted attention for a long time; its counterpart in the temperate zone is considered somewhat rare. In our temperate zone, we may classify megaloblastic anemia of pregnancy as:

1. Classical pernicious anemia occurring with pregnancy
2. Nontropical sprue in association with pregnancy
3. True megaloblastic anemia of pregnancy

From the Department of Obstetrics and Gynecology, University of Maryland School of Medicine.

CASE REPORT

Mrs. A. G. is a 28 year old white female, Rh positive, STS negative, para 2205, who first entered University Hospital in the thirtieth week of her gestation. Her chief complaints were hyperemesis and weight loss over a two-month period. One month prior to her admission, the patient became aware of small purpuric lesions over her body, which she had attributed to "insect bites." She also had noted increasing weakness and lethargy.

Family history was non-contributory.

Her past obstetrical history revealed that she

received two units of blood for postpartum hemorrhage after the delivery of her first infant. In 1952, she delivered premature twins, and five months later a D&C was performed for "dysfunctional uterine bleeding." The patient delivered with no difficulty a premature infant in 1954 and a mature infant in 1956.

Patient's usual weight was 123 pounds; her weight on this first admission was 108 pounds.

Physical examination revealed an asthenic, dehydrated individual who appeared older than her stated age of 28. She evidenced a muddy pallor; her tongue was coated, and there was some degree of papillary atrophy. Temperature was 100.4°F.; patient was normotensive. Diffuse petechiae were noted over the upper and lower extremities, as well as the trunk. Spleen and liver were not palpable. There was no edema. Neurological examination was within normal limits.

Admission hemogram revealed 5.7 grams per cent of hemoglobin with 3600 platelets and 2750 leukocytes with a normal differential. Patient's reticulocyte count was O. An examination of her peripheral blood smear evidenced a moderate difference in size and shape of the red blood cells; hypersegmented or "PA Polys" could also be seen. The blood indices were normocytic.

In view of the evidence of bone marrow depression, as demonstrated by anemia, leucopenia, and thrombocytopenia, bone marrow examination was performed, which revealed a markedly megaloblastic marrow with depression of megakaryocytes and the presence of hypersegmented neutrophiles.

Serum van den Bergh studies failed to demonstrate a hemolytic abnormality. The serum vitamin C level was 0.0, and serum Vitamin B_{12} level was normal. A glucose tolerance test resulted in a flat curve. There was no indication of any increased stool fat, and tubeless gastric analysis was performed with the positive demonstration of the presence of free acid. Thus, the clinical impression of megaloblastic anemia of pregnancy was confirmed.

The patient was given intravenous fluids to combat dehydration during her first day of hospitalization and then was started on folic acid therapy. For the first day of therapy, folic acid was given intramuscularly and, thereafter, orally. Soon after the institution of folic acid therapy, the patient tolerated foods orally and began to show an increase in both her weight and well being. She was discharged after 20 days to continue her folic acid and to be seen in the Outpatient Department. At the time of discharge, the patient had gained three pounds, was afebrile, and evidenced 8.2 grams per cent of hemoglobin. A rise in her reticulocyte count was first observed on the fourth day after institution of folic acid therapy and reached a maximum in two weeks (fig. 1). Upon discharge the patient had no vomiting or diarrhea; the petechiae were disappearing. During her visits to the Outpatient Department, a repeat study of her peripheral smear revealed a moderate achromia of the erythrocytes, and iron therapy was started with a further increase in both hemoglobin and erythrocytes (figs. 1 and 2).

Four days after the expected date of confinement, the patient re-entered University Hospital with spontaneous rupture of her membranes. Her weight at this time was 135 pounds. Seven hours later she had a spontaneous onset of labor. After an eight hour first stage and a five minute second stage, the patient, under local anesthesia, delivered a 2500 gram male infant spontaneously from LOA position. The infant's Apgar index was 7. Third stage was perfectly normal, with an estimated blood loss of 150 cc. The infant's hemoglobin at birth was 18.1 grams per cent. On the third postpartum day, both mother and infant were discharged in good condition. Folic acid was continued for one month postpartum. Upon the patient's discharge, maternal hemoglobin was 11.4 grams per cent.

Figures 1-4 demonstrate the relationship between the onset of folic acid therapy and increase in reticulocyte count, as well as Hb, RBC, WBC, and platetlet counts in this patient.

DISCUSSION

Patients presenting with the clinical syndrome of megaloblastic anemia of pregnancy usually do so in the third trimester of pregnancy or in the puerperium, and they will characteristically evidence deficient dietary intake, usually lacking animal protein, fruit, and green vegetables. Although the majority of patients live in poor economic circumstances, a few exceptions have been noted.[2]

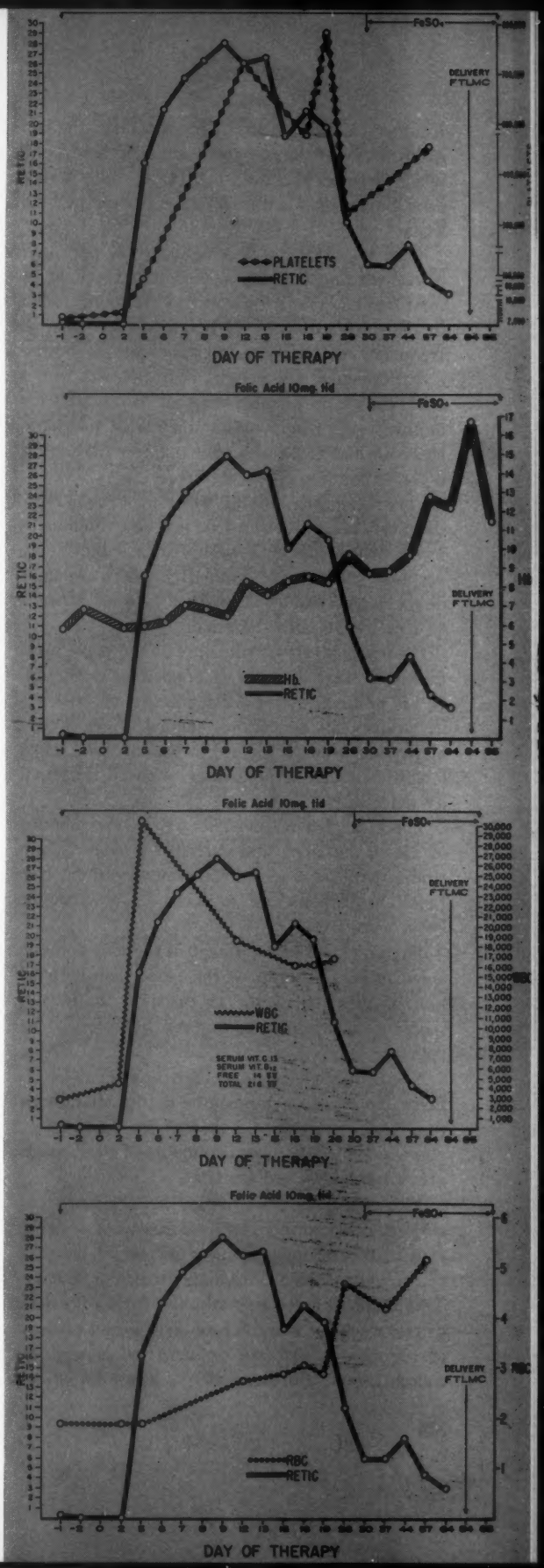
Gastrointestinal symptoms are quite promi-

nent, and excess nausea and vomiting are found in 40-50 per cent of patients. A history of increasing anemia, especially when associated with nausea, vomiting, or diarrhea, should arouse suspicion of megaloblastic anemia of pregnancy.[3] The onset of this disease may be insidious, but more frequently it is quite sudden, with a rapid fall in hemoglobin, in spite of iron therapy or even of blood transfusion. As Osler[1] observed, a characteristic feature is the rapid disappearance of the anemia spontaneously on interruption or termination of pregnancy.

The majority of patients with megaloblastic anemia of pregnancy are underweight. Fever is a common sign, but is not associated with any demonstrable sepsis.[2] Splenomegaly will also be observed in approximately one-third of the cases, and with proper treatment, there will be a gradual diminution in splenic size. In contrast to classical pernicious anemia as described by Addison, neurologic abnormalities are not seen in any of the patients with megaloblastic anemia of pregnancy. They do not have subacute combined degeneration of the cord.

The diagnosis of megaloblastic anemia of pregnancy depends on a full hematological investigation. Initial examination of the peripheral blood smear may show combinations of macro-normo or microcytosis, as well as variations in the size and shape of the red blood cells. In truth, careful examination of the peripheral smear is of greater value than is any calculation of blood indices. In most patients, the definitive diagnosis must depend on an examination of the bone marrow.

The first reported description of bone marrow changes in megaloblastic anemia of pregnancy was in 1936. In essence, the bone marrow changes are similar to those found in Addisonian pernicious anemia. Generally the marrow will show increased cellularity involving megakaryocytes, white blood cells, and nucleated red blood cells. The presence of true megaloblasts in the marrow may be taken as diagnostic. The degree of megaloblastic change and the number of megaloblasts, in general, parallels the severity of the anemia.[2] Megaloblasts are not normally seen in the bone marrow of pregnant women.[4] The megaloblastic cells are thought to represent an abnormality of red blood cell division, caused by deficiency or improper utilization of one or more hemopoietic



factors.[2] In addition to the megaloblasts, the bone marrow reveals large hypersegmented neutrophils which develop into the "PA Polys," also considered diagnostic when seen in the peripheral blood smear.

Focusing attention once again to the peripheral blood, we find that leukopenia is a frequent observation and that a low reticulocyte count is usual in the untreated case. It is difficult to judge the frequency of thrombocytopenia, but as marked a depression in the platelet count as was seen in our case would be most unusual. Infants born to mothers with megaloblastic anemia of pregnancy show normal blood and bone marrow findings, as do other children of the mother.

Other examinations of value in establishing a diagnosis are the serum iron and the Vitamin B_{12} levels, which are both within normal limits. Absorption studies of Vitamin B_{12}, which are an indirect assessment of "intrinsic factor," also fail to demonstrate any abnormality.

Gastric analysis usually reveals the presence of free acid. This is in direct opposition to the universal findings of the total absence of free acid in Addisonian pernicious anemia. Even gastric biopsy has been performed in patients with megaloblastic anemia of pregnancy, with no abnormality detected.[3]

There is also no evidence of excess amounts of fat in the stool, and careful four day balance studies with measured dietary intakes of fat have failed to demonstrate evidence of a sprue-like syndrome.

The objective of treatment in the megaloblastic anemias is restitution of the blood count, reduction of the size of the erythrocytes to normal, relief of all symptoms, and rehabilitation of the patient.

Adequate diet has long been known to have a favorable effect on the course of this disease entity. The patient should be encouraged to take a diet which includes liberal amounts of liver, meats, green vegetables, and fruits.

Although liver therapy may be ultimately successful, refractoriness to liver has been a significant feature of megaloblastic anemia of pregnancy, in contrast to Addisonian pernicious anemia.[5] This refractoriness may take the form of a delay of two weeks or more before there is any evidence of reticulocyte increase or increased hemoglobin concentration. Furthermore, it has been shown that liver extract given by mouth may produce a hematologic response; whereas concentrated intramuscular liver extracts do not. This observation led Wills[6] to the suggestion that these patients with megaloblastic anemia of pregnancy are deficient in some substance other than liver extract principle which is effective in pernicious anemia; namely, folic acid.

The name folic acid was given to a substance obtained in nearly pure form from spinach which substance was found to support the growth of two organisms commonly used in microbiologic assay; namely, Lactobacillus Casei and Streptococcus Fecalis. Substances with similar growth stimulating properties have also been isolated from liver, yeast, milk, casein, and other natural products. It has been shown that meat and vegetable products, with the exception of liver, lose much of their folic acid content during the process of cooking and canning. Today, folic acid is the drug of choice in megaloblastic anemia of pregnancy, and the use in properly diagnosed cases can at least assure that the patient will be in reasonable condition to face her labor.[7]

The pregnant woman requires a daily supplement of 2-5 mg. of folic acid, an amount which may easily be supplied in an ample diet.[8] In addition to inadequate intake and the added burden of fetal requirements, a nutritional deficiency may also be influenced in some instances by an alteration in the intestinal flora, which competes with the body for folic acid. The satisfactory remission by penicillin and aureomycin in megaloblastic anemia of pregnancy in Kenya, Africa, is thought to be due to the effects of these antibiotics in altering the intestinal flora.[9]

The administration of folic acid is followed first by the rapid release of reticulocytes (immature red blood cells) into the circulating blood; this event is succeeded by an increase in the number of mature corpuscles. The changes in the bone marrow with therapy are identical to those seen in Addisonian pernicious anemia. The megaloblastic character of the marrow rapidly disappears, and there is a striking proliferation of normoblasts. At the same time, the marrow becomes less and less hyperplastic. The degree of bone marrow hyperplasia and the magnitude of the preliminary increase in reticulocytes in the blood are directly proportional to the severity of the anemia.

The reticulocyte response is, therefore, recog-

nized as a useful objective measurement of the effectiveness of therapy. When an average therapeutic dose is given, the reticulocytes will usually begin to increase in three to five days after commencement of treatment, and a maximum response is seen in eight to twelve days. As the percentage of reticulocytes fall, the total number of red blood cells increases, and by the end of two weeks of treatment, the red blood cells have increased considerably. If no complications develop, the normal blood count should be obtained in four to eight weeks. The hemoglobin concentration may not, however, rise as rapidly as the red blood count. Platelet and white blood count will increase in parallel to the increase in both red blood cells and reticulocytes in the peripheral blood. Any bleeding tendency resulting from a deficiency of platelets would also be expected to disappear with the institution of proper treatment.

Clinically, we know that nutritional deficiency has caused megaloblastic anemia of pregnancy in most cases. Presumably, also, the requirement of the fetus for blood building factors is met from maternal stores. Whether or not these demands ever exhaust the maternal supply and thereby lead to the development of megaloblastic anemia is unknown. There is an increased incidence of this anemia in twin gestation, which clinical fact may be due to the increased nutritional needs of the twin fetuses, as compared to the single offspring.

There is a considerable interrelation and interdependence of factors which are required in the synthesis of red blood cell nucleoprotein. Both vitamin B_{12} and folic acid act as coenzymes at different stages in the biologic synthesis of nucleoprotein[10] We do know that there have been adequate responses in megaloblastic anemia of pregnancy to the administration of vitamin B_{12}. Experimentally, it has been shown that when vitamin B_{12} is administered to a normal patient, the urinary excretion of folic acid increases. It is possible that in the presence of a partial deficiency of folic acid, such as is seen in megaloblastic anemia of pregnancy, that vitamin B_{12} by mass action may mobilize the folic acid remaining in the body tissues, thus causing a partial, or even complete, remission of the disease. However, when tissues have been so depleted of their folic acid content, then therapy with vitamin B_{12} will fail to produce a remission of megaloblastic anemia of pregnancy. It has also been postulated that vitamin B_{12} influences the storage, absorption, and utilization of folic acid. There is definitely a finely adjusted balance between vitamin B_{12} and folic acid. Although much has been learned concerning the importance of both of these vitamins in metabolism, their interrelation one to another and the manner in which they participate in the pathogenesis of megaloblastic anemia of pregnancy is far from being entirely clear.

The prognosis for megaloblastic anemia of pregnancy at one time was very poor. Before the days of blood transfusion, liver therapy, and folic acid, mortality rates of between 50 and 75 per cent were being reported; however, the outlook for both the mother and the fetus has changed radically with the discovery of folic acid.

In conclusion, it seems likely that the syndrome of megaloblastic anemia of pregnancy does *not* represent a homogeneous group. In some instances, infection may interfere with the utilization of folic acid; in other circumstances, hemorrhage and multiple pregnancy increase the demands for folic acid, while, at the same time, poor diet and impaired gastrointestinal absorption reduce the natural supply of folic acid. Regardless of the exact mechanism of the production of megaloblastic anemia of pregnancy, folic acid should produce a hematological response.

University of Maryland
School of Medicine
Baltimore 1, Maryland

REFERENCES

1. Osler, W.: Brit. M.J. **1**:1, 1919.
2. Lowenstein, L., Pick, C. and Philpott, N.: Am.J.Ob-Gyn. **70**:1309, 1955.
3. Callender, S. T. E.: Quar.J.Med. **13**:75, 1944.
4. Wolff, J. R. and Limarzi, L. R.: J.A.M.A. **28**:482, 1945.
5. Davidson, L. S. P.: Blood **3**:107, 1948.
6. Wills, L. and Evans, B. D. F.: Lancet **2**:416, 1938.
7. Israels, M. C. G. and DaCunha, F. A. L.: Lancet **2**:214, 1952.
8. Spies, T. D.: Surg., Gynec. & Obst. **89**:76, 1949.
9. Foy, H. and Khondi, A.: Brit.M.J. **1**:380, 1951.
10. Wintrobe, M. M.: Clinical Hematology, Philadelphia, Lea and Febiger, 1956.

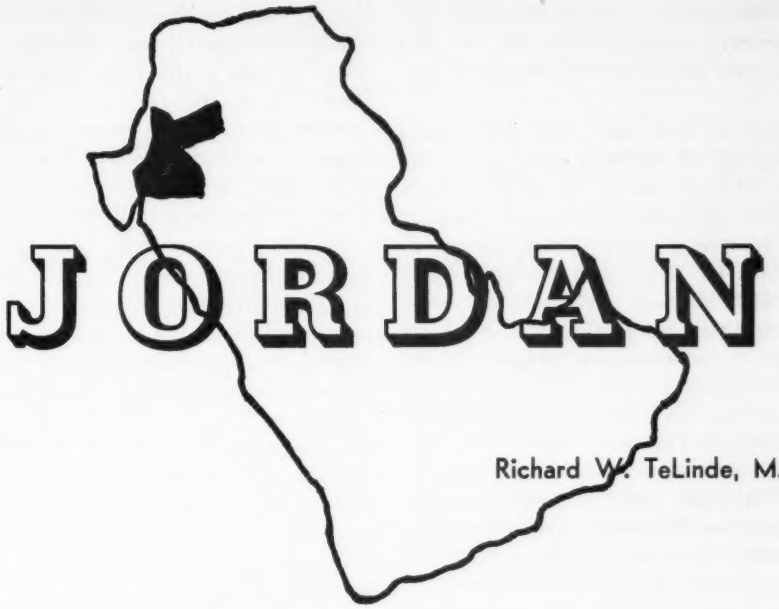
Medical Mission To

Medical observations and experiences by a member of the Medico team assigned to the poverty-stricken country of Jordan.

On the sixteenth of November, 1958, a group of six Johns Hopkins doctors and a nurse anesthetist from the Sinai Hospital left Baltimore for a month of medical work in Jordan. They were sent by Medico, a privately endowed organization interested in sending medical help to underprivileged and, hence, underdeveloped countries. Angier Biddle Duke is president of the organization and Peter Commanduras, M.D., the director general. The local representative is Edgar Berman, M.D., who was responsible for assembling the team of Hopkins specialists and Mrs. Lilly Rim, the nurse anesthetist. It is the intent of Medico to send medical teams to several countries, of which Jordan was selected to be the first. This selection was made as the result of a survey made by Dr. Commanduras, who had made a trip to several countries where the medical need was thought to be great. Our experiences in Jordan indicated that its selection was, indeed, a proper one on the basis of need.

Hospital beds were found to be extremely inadequate and equipment deficient. When Jerusalem was divided, at the time of the Israeli-Arab armistice, it happened that there were no general hospitals on the Arab side, except, as fate would have it, the new Hadassah University Hospital. This institution stands on Mount Scopus, an Israeli island in Arab territory. At agreed intervals, a convoy is permitted to enter Arab territory from Israel to bring supplies to a garrison of soldiers stationed in the university buildings. Thus, the university and hospital lie deteriorating in the desert sun. Neither the Jews nor the Arabs have access to the buildings for the purposes for which they were intended.

In the meanwhile, the Arabs are using two makeshift general hospitals in Jerusalem. The Augusta Victoria Hospital, where we did most of our work, was built shortly after the turn of the century by Kaiser Wilhelm II as a winter palace. A statue of the Kaiser and Kaiserin still stand in the courtyard. The palace was rapidly converted for hospital use at the time of the Israeli-Arab armistice and has a capacity of approximately 280 beds. There is one poorly equipped operating room. The hospital is staffed by Arab



Richard W. TeLinde, M.D.

doctors who are paid by UNRWA (United Nations Relief and Works Agency). Its use is for the refugee sick who have been screened by other UNRWA employed doctors at the refugee camps. The camps, incidently, are staffed by doctors with general practice training, who see from 100 to 150 patients a day and whose chief function is to screen the seriously ill from those with minor ailments and the malingerers.

The other general hospital in Jerusalem available to the public is a government hospital for the non-refugee poor. It was an old Austrian hospice which was quickly converted into a makeshift hospital at the time of the armistice. It is even more lacking in equipment than the Augusta Victoria. Surgery in these hospitals with inadequate equipment and assistance was difficult, and one can have only admiration for the Arab doctors who are attempting to cope with the situation as it exists.

Elsewhere in the country there were a few smaller, poorly equipped government and UNRWA operated hospitals. One notable exception was in a small community visited by some of the members of our team, where a new, small, but surprisingly complete general hospital was operated by a husband and wife team of competent American surgeons, under the auspices of the Southern Baptist Church.

There are approximately four well trained general surgeons in the kingdom of Jordan. I say approximately, because there is always a question as to what constitutes adequate training. The population of the country is 1,500,000, including the 500,000 refugees; thus, it is obvious that the surgical needs of the country can scarcely be touched. James Isaacs, M.D., the general surgeon in our group, was especially interested in chest surgery and visited a tuberculosis sanitarium, where he saw innumerable cases of pulmonary tuberculosis badly in need of surgery. There were, also, countless children with mitral disease, resulting from rheumatic fever, and many with congenital heart disease who could have profited by surgery. There is no urologist, and the urologic problems are many.

Gerhard Schmeisser, M.D., our orthopedist, visited a crippled children's home and came away

with the belief that about 50 per cent of the children could have benefited from corrective surgery. The training of someone in the simple procedure of properly applying casts for club feet would be of great benefit to many neglected children.

Helen Ossofsky, M.D., our pediatrician, found a tremendous field of neglected pathology among the children. Malnutrition was the greatest single problem. There was more of this among the poor of the non-refugee population than among the refugees, whom UNRWA feed remarkably well at a cost of $1.25 a month. Their diet lacks meat and green vegetables, but 1500 calories a day are supplied, and, on the whole, the refugees did not appear undernourished. Each camp had a supplementary feeding kitchen where pregnant women and others in need of extra calories were fed. We were told that there were several instances of civilians from the underfed general population infiltrating into the camps, a situation which becomes readily understandable to a visitor of this poverty stricken, barren, desert country.

There is one bright spot in the pediatric picture. Mrs. Vester, an American who has spent 77 of her 80 years in Palestine, has built, with funds which she has personally solicited, a new 65 bed pediatric hospital in the old city of Jerusalem. It is a model hospital in every respect, except that it lacks a trained pediatrician; however, there is a young Arab studying at the University of Pennsylvania who expects to return and be in charge.

The need for ophthalmologic surgery is tremendous. On simply walking along the street, it is obvious to anyone that a large percentage of the adult population have corneal opacities. Since Crusader times, there has been an ophthalmologic hospital in the old city of Jerusalem, financed by the Order of St. John. At present, a well trained British ophthalmologic surgeon is in charge, and he has two Arab assistants who were trained in England. The level of ophthalmologic surgery is far above that of most medicine and surgery in Jordan, but the need far exceeds the available surgery, and blindness is needlessly excessive. Charles Iliff, M.D., worked daily with the local surgeons, but dozens of ophthalmologic surgeons would be required to clean up the backlog of eye disease. The need of corneal grafts is tremendous; but, unfortunately, the Moslem religion, which forbids mutilation of the body after death, prevents the obtaining of such grafts. Dr. Iliff brought from the States some dried corneal grafts, which were soon utilized. Although the Moslems refuse to take grafts from dead Moslems' eyes, there was no objection to the use of the non-Moslem grafts which were supplied. Dr. Iliff hopes to establish a corneal graft bank whereby they can be supplied to those parts of the world in which they are not otherwise available.

Donald Proctor, M.D., our otolaryngologist, with Dr. Ossofsky and Dr. Iliff, made a survey of 605 children, part of whom were from refugee camps and part from the general population. In general, they found the children from the refugee camps in better condition than the non-refugees, suggesting that the controlled but poor refugee diet, as judged by American standards, was better than that of the average poor non-refugee. Among the children were found minor conditions which could easily be remedied by simple preventive measures, which measures would undoubtedly prevent many of the more serious conditions found among the adults. One of the incidental findings in this survey was the absence of dental caries. Even in the adult population, teeth were often observed to be in excellent condition in spite of minimum care.

The practice of gynecology in Jordan is quite different from that in the western countries. It is influenced to a marked degree by custom and religion. Contrary to my expectation before going to Jordan, we found no difficulty in making pelvic examinations on Moslem women. Our practice was entirely on refugees, many of whom were of the lower class, educationally speaking, and, hence, more bound by ancient customs; yet I experienced no difficulty in examining them.

I was interested to learn something of the incidence of cervical cancer among Arab women. Was the well known relative immunity of Jewish women to cervical cancer present in Arabs, who are also of Semitic origin? The Arabs, too, circumcise male children ritually and are strict about doing so. On my first morning, I discovered a cervical cancer in a 22 year old woman. I asked Dr. Bishara, my opposite number, about the incidence. He replied that he had seen a good deal of it, but since he had only practiced on Arab women, he had no basis for comparison. Later, I met the professor of gynecology at Damascus,

who had been trained in Paris. He reported that he could note no difference in the incidence between the French and the Arabs. It would appear, then, that male circumcision is not the factor responsible for the relative immunity of Jewish women.

The most common complaint of Arab women in the gynecologist's office is infertility; indeed, it was not at all uncommon for a woman of 40, the mother of three or four children, to complain of infertility because she had not been pregnant for two or three years. Quite a contrast to American women! Failing to bring forth children, she feared that her husband would take on another wife. Although polygamy is common, especially among the uneducated, it apparently is not popular with the wives. If a wife is absolutely sterile, she will almost certainly be divorced and sent back to her family. I saw a few such women, and they were almost psychopathic with fear of such a fate. Divorced for sterility, an Arab woman has no future; she has no chance of remarriage, for the assumption is always that she, not her husband, is responsible for the sterility.

Hysterectomy for benign disease, such as fibroids in the premenopausal woman, is permitted by the woman only after much persuasion. The Arab woman will suffer pain and much bleeding rather than permit the removal of her uterus and, thereby, definitely end her chances for pregnancy.

Pelvic infections were relatively common as a cause of sterility. Bacteriologic studies could not be made, but I am inclined to believe that many were nongonorrheal in origin. It was the opinion of Dr. Bishara that many infections were due to packing of the vagina with various crude medications by midwives.

The Arab man believes that he has an inalienable right to a large family. The fact that he is supported by charity does not alter his viewpoint; in fact, idleness and lack of other interests probably accentuate his interest in his immediate family. The birth of a baby is an occasion of great moment in a refugee camp, where other diversions are few.

The second most common gynecological complaint had to do with prolapse, cystocele, and rectocele. Multiple and rapidly successive childbearing under the direction of untrained midwives is undoubtedly responsible for this, and hard physical labor, also, certainly plays a part.

Modern anesthesia is almost unknown in Jordan; the only anesthesiologist is in the army, and elsewhere, anesthetics are given by untrained nurses. Sometimes oxygen was not available as we operated under pentothal; but, in spite of this handicap, we had no anesthesia casualties. Mrs. Rim gave daily instructions to several nurses who were most anxious to learn, and I believe she contributed much knowledge of permanent benefit to anesthesiology in Jordan.

On returning home from such a mission, one naturally reviews what has been accomplished. We all did much work in our respective fields, but it was as nothing compared to the need. We assisted and were assisted by doctors in our respective fields, and we hope that something was learned. An immediate need is for surgical instruments and operating room equipment. We have made recommendations to Medico that such equipment be sent and have been assured that it will be. This will lighten the work of the Arab doctors who are carrying on.

It is our aim to have some selected young Arab doctors join our resident staffs. This will ultimately be of great benefit, but the scientifically trained man must have modern facilities to work with on his return to Jordan. Of those who have come to this country, many have married American women and have remained here; others sincerely want to return to their native country. They realize the poverty and the political uncertainty of their country and are willing to take their chance with these factors, but they must have a modern hospital in which to work.

Our long range recommendation is for a Jordanian hospital of approximately 300 beds. In this institution there should be at least one well trained specialist in each major field of medicine and surgery. Difficult cases could be sent there, and the doctors from the outlying districts could attend staff rounds weekly. Such an institution would serve as a medical educational center, without which medical progress is impossible. If the idea of such a center could be brought to fruition, we believe that our mission will not have been in vain.

The Johns Hopkins Hospital
Baltimore 5, Maryland

control the tension–treat the trauma

...Pathibamate® 400 200

meprobamate with PATHILON® tridihexethyl chloride Lederle

greater flexibility in the control of tension, hypermotility and excessive secretion in gastrointestinal dysfunctions

PATHIBAMATE combines two highly effective and well-tolerated therapeutic agents:

meprobamate (400 mg. or 200 mg.) widely accepted tranquilizer and...

PATHILON (25 mg.)—anticholinergic noted for its peripheral, atropine-like action, with few side effects.

The clinical advantages of PATHIBAMATE have been confirmed by nearly two years' experience in the treatment of duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

Two dosage strengths—PATHIBAMATE-400 and PATHIBAMATE-200 facilitate individualization of treatment in respect to both the degree of tension and associated G.I. sequelae, as well as the response of different patients to the component drugs.

Supplied: **PATHIBAMATE-400**—Each tablet (yellow, 1/2-scored) contains meprobamate, 400 mg.; PATHILON tridihexethyl chloride, 25 mg.
PATHIBAMATE-200—Each tablet (yellow, coated) contains meprobamate, 200 mg.; PATHILON tridihexethyl chloride, 25 mg.

Administration and Dosage: **PATHIBAMATE-400**—1 tablet three times a day at mealtime and 2 tablets at bedtime.
PATHIBAMATE-200—1 or 2 tablets three times a day at mealtime and 2 tablets at bedtime.
Adjust to patient response.

Contraindications: glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

THE PUBLIC MENTAL HOSPITAL

Eugene B. Brody, M.D.*

PUBLICLY, AMERICANS consider the mentally ill in terms of sympathy, an attitude which expresses the importance we attach to individual well being. Privately, however, our fears and doubts tend to be reflected in institutionalized ways of behaving in relation to the problem of mental illness. Such institutionalized ways of behaving represent unthinking conformity to cultural norms defining proper, legitimate, or expected modes of action or of social relationship. They reflect a society's accepted modes of conduct in the face of those regularly encountered experiences which evoke strong feelings and require decisions. In Talcott Parsons' words, they provide "a mode of 'integration' of the actions of the component individuals" of society.

The more extensive and complex a society becomes, the less it can afford random behavior on the part of its individual members, and patterns of institutionalized behavior reduce the possible amount of random social activity. Stated another way: as a society becomes more complex, its inherent system of social controls tends to become more rigid. This control system has been augmented by state participation in many functions originally carried out by the family, among which is care of the sick, particularly the mentally ill. Some other functions transferred from family to government include the physical protection of the home, the support of widows and orphans, the formal education of children, the economic support of the unemployed, and the custody of the aged. The assumption of these functions by government has confronted us with the task of evolving social controls flexible enough to maintain individual dignity and identity and, at the same time, strong enough to assure group survival.

The institutions of a society, in terms of the various needs which they must reconcile, may be regarded as symptomatic of its inner conflicts, in the same way that the character of an individual reflects his techniques of integrating conflict solution into a way of life. In a sense, social institutions are compromise formations, reflecting on one hand the needs, drives, and wishes of the social organism and on the other, the forces which inhibit the expression of these needs, the anxieties which they occasion, and the threats of disorganization which they suggest.

Methods for dealing with the mentally ill are particularly sensitive to society's conflicting needs to deal with men as individuals or in the mass. The picture is complicated by competing economic and humanitarian motives, as well as traditional attitudes of fear, hatred, and guilt directed toward psychotic persons. The development of institutional patterns of behavior toward the mentally ill was inevitable because this is the instance *par excellence* in which disease is immediately reflected in social behavior.

One pattern in America is the isolation or banishment of the psychotic person from the community. This may be understood in terms of the removal of a nonconforming or a nonpredictable unit from most aspects of social life. Segregation of the mentally ill is an aspect of the control process which insures individual conformity to the customs and values of the group or tries to establish the predictability of its constituent members; the banishment also serves the less obvious function of anxiety-reduction for the group—out of sight, out of mind.

From the economic point of view, it is desirable to deal with mentally ill persons in as large numbers as possible because of the lack of a definitive, inexpensive, easily-administerd treatment for psychosis, particularly schizophrenia. The expense of state hospitalization is, to a considerable degree, that of running a boarding house, and the bigger the boarding house, the less it costs per individual unit. Our ideals and aspirations for the individual are forgotten when we consign him to

---

This paper is based on the first annual Beta Sigma Phi lecture, delivered at the Spring Grove State Hospital, November 25, 1958.

* Professor of psychiatry and director, The Psychiatric Institute, University of Maryland School of Medicine, Baltimore.

AS A SYMPTOM OF SOCIAL CONFLICT

An analysis of the role of the large mental hospital in today's society and a prognosis for its future.

the relative anonymity of a 2,000-bed institution. In this sense, the public mental hospitals which cover the face of rural America represent a symptom of persistent conflict: our wish to cure, to help, to be human, on the one hand; on the other, to treat the psychotic person as a number rather than as an individual, to rid ourselves of the discomfort and the nagging awareness of inadequacy which he engenders in us.

Symptoms embody defenses against anxiety and unacceptable wishes, but their success in this respect is limited. Furthermore, they, themselves, cause the patient additional difficulty. So, too, do mental hospitals. Some of our current discomfort regarding the hospitalized mentally ill seems to stem from a perception of them as a deprived social and political minority in our midst. In fact, the well-intentioned and generally useful and appreciated efforts made by various clubs and organizations on behalf of mental hospital patients—the presentation of television sets, the visiting at holidays, the organization of occasional parties, the presentation of theatricals—have much in common with the activities of public spirited citizens on behalf of any socially and economically depressed minority. Mental illness is a social problem in our society because, in the course of dealing with it, we abrogate many of the values basic to American social institutions, particularly those concerned with the importance of individuality. It is also a social problem insofar as those afflicted do not play their expected social roles and do not subscribe to the generally accepted value systems.

The social problem was, perhaps, not so pressing in the 1830's, when the population was smaller and family groups retained more of their functions. At that time, there developed what was called "the moral treatment of insanity," which emphasized close and friendly association with the patient, sympathetic but understanding discussion of his difficulties, and the daily pursuit of purposeful activity. It all took place in small hospitals, where the doctor lived in intimate contact with his patients. Charles Dickens, after a visit to America, noted that this system encouraged "a decent self-respect" in the hospitalized person. It declined, however, after the 1850's, when emphasis on economy and imitation of industrial methods led to the acceptance of larger institutions (1).

Significant to the increase in population and the expanding size of the mental hospitals was the influx of immigrants. Physicians of colonial ancestry who were filled with compassion for the mentally ill with similar values and background were often revolted by the "ignorant, uncouth, insane foreign pauper." (1) The past 100 years' history of our public mental hospitals has been increasingly that of the dependent, economically depressed insane. The connection between economic and psychiatric unfitness was noted early by Dorothea Lynde Dix, who considered this to be a Federal problem. In 1848, she petitioned Congress for the appropriation of ten million acres of land for the specific purpose of caring for the deprived mentally ill, whom she characterized as "wards of the nation." (2) National responsibility, as opposed to state responsibility, for the economically unfit psychotic has not, however, been accepted today, apart from the Veterans Administration.

The economic impact of psychosis upon the state is so vast as to be almost undefinable. Schizophrenia strikes mainly at people who have a long time to live, and our society is committed to the philosophy of supporting its disabled members. Most schizophrenics become ill during the ages when people learn a trade or a profession, when they become established in their occupations, raise families, and turn the wheels of the community. Since the average stay of a schizophrenic in a state mental hospital has been estimated at about 15 years, the cost is staggering, even when it is distressingly low per individual patient day. Further, our actions do not reflect the value we attach to the realization of individual potential. An implied readiness to accept the status quo is indicated by some recent figures: it has been estimated that less than one per cent of total state mental health budgets is expended for research—$4,000,000 of

a total expenditure of about $560,000,000. (3)

The economic impact of psychosis upon society has its counterpart in the influence of socioeconomic conditions upon mental illness. The studies of Faris and Dunham and others, beginning almost 20 years ago, show some agreement on the following points: (4)

1—Schizophrenia rates in different cities show an expected typical pattern, with the high rates concentrated in areas of low economic status and with rates declining in every direction toward the periphery.

2—Manic-depressive rates show a much wider scatter and a general lack of conformity to the concentric circle pattern.

3—Persons residing in areas not primarily populated by their own ethnic or racial group show disproportionately higher rates of schizophrenia than members of the numerically dominant ethnic or racial group.

The factor of social stratification has recently been studied by a group at Yale, headed by Hollingshead and Redlich. (5) Their evidence suggests that the least favored social stratum supplies a disproportionate number of schizophrenics who tend to become chronically hospitalized. The unskilled and semiskilled workers who have an elementary school education or less and who live in the poorest areas of the New Haven community produced eight times as many schizophrenic patients as the groups in which the adults held college degrees and responsible positions. Proportionately, 31 times as many lower-class as upper-class patients were under care for 21 years or more.

Some authors feel that growing up in a poorly-integrated lower-class family, with the development of insecure and negative social attitudes, may interfere with the child's growing ability to relate to others. This, theoretically, should promote the eventual development of the kind of interpersonal isolation seen in schizophrenia. Faris and Dunham have postulated that the tendency of isolated personalities to drift down the social scale results in their accumulation in the poorest quarters of the city. Hollingshead and Redlich, on the other hand, suggest that the over-striving and over-aspiring person is the one who breaks down with schizophrenia or neurotic illness, and that breakdown usually follows a period of upward mobility in the social structure. Several other studies, which confirm a higher incidence of schizophrenia in the lower socioeconomic strata, suggest not a downward drift, but an active segregation of schizoid, pre-schizophrenic, and schizophrenic persons in rooming-house areas, where a degree of social anonymity is possible.

Whitely, in England, (6) studied a group of social isolates, the homeless men of London's lodging houses and reception centers. These men showed a high incidence of schizophrenia, particularly in its paranoid form. They seldom sought psychiatric aid, and when they did come to treatment, they responded poorly and relapsed frequently. In general, schizophrenic illness appeared to have existed before the men took up the vagrant life, while depressive illnesses often occurred for the first time in men of 40 to 50 with some evidence of previous instability, after a period of rooming alone.

In England, where psychiatric treatment is fairly standard under the National Health Service, class differences in treatment opportunities have not been suggested as a basis for the accumulation of lower class schizophrenics. The men in Whitely's study drifted into the reception centers and lodging houses as they became ill and unable to hold jobs, having neither family nor friends to care for them, and in the new environment, their symptoms quickly became florid. Social isolation, in Whitely's opinion, exerts its biggest influence in the post-hospital stage: "At the time when the recovering psychiatric invalid needs the security of his family and home and the assurance and encouragement of his friends and relatives, the homeless man is returned to the cold solitude of his bunk in a friendless dormitory . . . the climb is too severe—and he relapses and continues to relapse, and the accumulation of similar cases continues."

In contrast to this point of view, emphasizing the disintegration of the lower-class family, the Yale study in America emphasizes social class influences on treatment. The Yale researchers concluded that the tendency for lower class schizophrenics to become chronic may be determined by the nature of their referral for treatment and the kind of treatment available to them.

Lower class schizophrenics in America are referred by the police, the criminal, and the probate courts. Upper class patients are concentrated in state hospitals; two-thirds of all upper class patients are treated in private practice, and those

who do come to hospitalization are much more likely to have outpatient treatment both before and after.

The percentage of patients who receive some form of psychotherapy decreases as one moves from the higher to the lower social levels, as does the nature of the psychotherapy; as the socioeconomic scale is descended, psychotherapy is aimed less at uncovering and resolving the conflicts behind the symptoms, and more emphasis is placed on direction, emotional support, and group therapy. Members of the least-favored socioeconomic group are handled almost exclusively with custodial care and the major organic methods.

To some degree this may be a function of differences between doctors and patients. The upper class physician behaves more—and is perceived more—as a directive authority when dealing with a lower class patient than with one of similar level, who shares similar aspirations and values and with whom he feels more comfortable.

Within the large state hospitals, except for the occasional person treated in psychotherapy by a resident in training, a patient's major staff contact is with the aide who transmits information upward in the hierarchy to decision-makers in the nursing or medical echelons. Immersion in this culture, with rigid lines of authority and social stratification, is probably significant for the future of the socially and economically deprived schizophrenic, himself the product of social stratification. This is clarified by Goffman's analysis of the large mental hospital as a total institution: an establishment set up to accomplish certain aims for large blocks of people. (7) Other examples of total institutions are hospitals, sanitoria, jails, army barracks, boarding schools, and monasteries. In all of these, sleep, play, and work go on in the same place in the immediate company of a large group of others who are treated alike, with a single directing authority and an overall rational plan. The handling of many human needs by the bureaucratic organization of blocks of people allows the use of relatively small numbers of supervisory personnel, who see that everyone does what is expected of him in a situation where one person's infraction stands out in relief against the compliance of others.

This type of existence, to which Goffman, refers as batch living, contrasts more pertinently with family life than does solitary living. The solitary and socially anonymous person retains his individuality to a significant degree, not only in fantasy, but in his freedom of action. In contrast, the "stripping process" at the beginning of institutional life involves a type of standardized defacement: "ego-invested separateness from fellow inmates is . . . diminished in many areas of activity; family, occupational, and educational career lines are chopped off, and a stigmatized status is substituted."

In the background of the sociological stripping process is the characteristic authority system of the total institution: First, authority is of the echelon kind. Any member of the staff class has certain rights to discipline any member of the inmate class. Second, the authority of corrective sanctions is directed to a great multitude of items of conduct of the kind that are constantly occurring and coming up for judgment. Third, misbehaviors in one sphere of life are held against one's standing in other spheres. As Goffman puts it, "The system of authority undermines the basis for control that adults in our society expect to exert over their interpersonal environment and may produce the terror of feeling that one is being radically demoted in the age-grading system . . . the desire to 'stay out of trouble' in a total institution is likely to require persistent conscious effort and may require the inmate to adjure certain levels of sociability with his fellows in order to avoid incidents with restrictive consequences."

This type of social organization presents hazards for the psychotic patient. His opportunity to have need-gratifying experiences which also increase his self-esteem is severely limited. He is far from the sources of authority and security. In the batch-living situation, immersed in a sea of other sick people, the lower class schizophrenic, who has already learned his place the hard way, may find it easy to abandon the struggle for individuality. The patient who is able to conform to the mores of batch-living becomes the successful citizen of the colony; thus the schizophrenic way of life can become institutionalized.

What conclusions might be drawn from this view of the situation?

First, it seems inevitable that the large mental hospital, whether described in terms of a thousand or of multiples of a thousand beds, must ultimately disappear. It is as anachronistic on today's landscape as a dinosaur, and, as the dinosaurs when

they were headed for extinction, it uses its resources mainly to maintain itself. Its very bulk prevents it from achieving the social function for which it was destined. More huge colonies for the mentally ill will only provide bottomless sinkholes into which our public funds will disappear and sources of unending frustrations for the professional staffs which man them.

Second, although we expect the gains from drug and metabolic investigations to continue, we must devote more attention to the social functions of the psychiatric treatment unit: its role in relation to the family settings of psychotics; its structure in relation to the other social structures which promote psychotic behavior; its function as an agency for the care of the economically unfit, the inadequate, and the rootless people of our society. It will probably be necessary, also, to dissect out and separate some of the other combined social and clinical functions of the hospital. Thus, we may have smaller and more specialized institutions to deal with problems now lumped together: the geriatric and senile, the congenitally defective, the psychopathic personalities, and the psychotics.

We are beginning to realize the value of small psychiatric services in general hospitals. Perhaps state supported units of this kind will be more economical in the long run than bigger and bigger institutions. We know that, as Mike Gorman (3) has emphasized, "thousands of hospitalizations can be avoided, postponed, or shortened by establishing lines of defense in the communities—clinics, half-way houses, sheltered work-shops, rehabilitation agencies, community health centers" and the like. A recent example of a new approach is the Diagnostic and Distribution Center in Philadelphia, opened for the dual purpose of conducting research and offering service to the skid row inhabitants, many of whom have histories of intermittent admissions to state hospitals.

It has been said that research represents the intelligent form of compassion. Effective community service and research can be intimately linked in a number of areas. We are interested in what goes on in people and between people before they reach the point where hospitalization is necessary. We wonder what areas of the community supply the greatest numbers of chronic state hospital patients, what characterizes these areas, how the process can be interrupted, and what hidden functions hospitalization may serve for the community as well as the patient and his family. We wonder why some mentally ill people come to hospitals while others remain outside. We wonder how social conditions, in their impact upon the family and the individual, increase the likelihood of psychotic behavior.

The development of state supported outpatient centers, geared for both research and treatment and located in the problem areas of the community, may provide part of the answer. Such centers will permit an early case finding program so that people may be seen while it is still possible to investigate and treat the mental—and the social—illness in its earliest stages. They can provide loci for long term follow-up studies and should ultimately become so well integrated into the community that the less privileged patients—especially the younger ones—can come into treatment without having to be filtered through punitive channels.

In essence, we look forward to a decentralization of public psychiatric facilities, investigation and therapy of the social conditions which produce so many economically dependent chronic schizophrenics, and the involvement of state governments in community rather than colonial work with patients. In this way we may be able to do something about the indefinite exile of so many of our potentially productive fellow citizens from active life. We may also make some progress in reconciling our social actions with our social values.

University of Maryland School of Medicine
Baltimore 1, Maryland

REFERENCES

1. Greenblatt, M., Levinson, D., and Williams, R. H. (Eds.): *The Patient and the Mental Hospital.* Glencoe, Ill., Free Press, 1957.
2. Deutsch, A.: *The Mentally Ill in America,* ed. 2. New York, Columbia University Press, 1949.
3. Gorman, M.: *Every Other Bed.* Cleveland, World Publishing Company, 1956.
4. Faris, R. E.: *Social Psychology.* New York, Ronald Press, 1952.
5. Hollingshead, A. B. and Redlich, F. C.: *Social Class and Mental Illness.* New York, John Wiley, 1958.
6. Whitely, J. S.: Mental Hygiene **42**:497-503, 1958.
7. Goffman, E.: The Characteristics of Total Institutions, Symposium on preventive and social psychiatry, Walter Reed Army Medical Center, U. S. Government Printing Office, Washington, D. C., 1957.

Handwriting Trouble? . . .

We All Have Them—So Does Pharmacist

Robert Greengard

WHEN IT IS CONSIDERED how much high-priced education, expensive research, and back breaking study form the background of even the simplest prescription, it seems regrettable that any prescription should be prevented from immediately accomplishing its purpose. Yet, few prescribers realize how often the prescription which was received so thankfully by the patient on, say, Thursday afternoon, is not being used before Saturday or Monday because the pharmacist had to consult the doctor and couldn't find him. The purpose of this letter is to high-light a few of the reasons for delay.

THE FOLLOWING FACT SHOULD BE REMEMBERED IN CONNECTION WITH THE DIFFICULTIES DESCRIBED BELOW: MORE OFTEN THAN NOT, THE PRESCRIPTION REACHES THE PHARMACY *AFTER THE DOCTOR'S OFFICE HOURS.*

Superscription

Many doctors omit the name, address, or age. These omissions deprive the pharmacist of very essential means of identification. Their lack may not occasion very *long* delays, but they can be a source of embarrassment in addition to the few extra moments it takes to make sure the medicine is going to the right patient. This situation is made more acute by the fact that the person waiting outside is very often just a casual messenger who can answer no question about the patient.

Ingredients

The prescriber should always write all the facts he knows in regard to the nomenclature and description of a patented item, such as strength, (NEVER assume there is only one strength), coating, manufacturer, etc. These facts may enable the pharmacist to interpret an ambiguity at once rather than make the patient wait until the doctor's next office hours to check the intent. The following examples are taken from experience:

1) Rx *flexilon 250 mg*
The doctor evidently changed his mind while writing. The strength enabled the pharmacist to give Flexin at once, since Flexilon is of a different strength.

2) Rx *tetracyclin 250 mg*
Without the strength, the pharmacist would have dispensed "Tetracydin," although the doctor is seen to intend "Tetracycline." (Final "E" is often omitted by European-trained doctors).

3) Rx Phenergan Expectorant RED
Phenergan Expectorant is green, but he obviously intends the red one with codeine.

4) Rx Equanil #20 Tabs.
When this was written, the doctor did not realize that a new strength had been introduced. If he had written the "400mg" as a matter of course, the patient could have started medication at once and without any complicated explanations.

5) Rx Dimethylane Robins
if the doctor had not had the foresight to write "Robins" the patient would have received Dimethylane, an antidysmenorrheic, instead of Dimetane Robins, an antihistamine, for her urticaria. If it is a tablet, include this word in the Rx. Capsule likewise.

6) Rx Mephosal
There is a tablet *and* a capsule . . . different formulas. Patient had to wait.

7) Rx Dexedrine 5mg—Signa:
one daily at 11 a.m.
Tablet or spansule? Messenger was a girl about 7 years old. Patient had to wait. A misplaced letter or illegible

Reprinted from *New York Medicine*, Vol. 15, No. 3, February 5, 1959.

script can cause delay that would be painful to the patient. As in this striking example:

8) Rx

thoragin Syr. thoragin Syr.

Theragran Syrup? Thorazine Syrup? . . . and the doctor was not available for 3 days!

The Signa

This is the part of the prescription that is most likely to send the pharmacist to the phone in search of the prescriber—and no one but the prescriber will do in most cases.

1) tid Q.I.D.? or T.I.D.? (Is it a "4"?)

2) qid Q.I.D. or Q.D.?

3) tid B.I.D. or T.I.D.?

4) pm P.M. or P.R.N.?

5) T.I.W.--i.e. 3 times weekly. Since this is not an orthodox abbreviation, but is an unexpected mixture of English and Latin, it must be written with great clarity to avoid having it mistaken for "T.I.D."

6) Sig ÷ hs This might be "T.I.D." since many people do not cross their "T"'s. This signa is "H.S."—the dot was meant to be a period after the "H".

We all know that medically it is seldom a threat to life if the patient takes a tablet 3 times a day instead of twice. To the patient, however, a wrong dose is a poisonous dose, and the pharmacist must face that fact when forced by an illegible or otherwise doubtful prescription to choose a course which will cast no doubt on his own professional qualifications or on the doctor's. When he receives a prescription of questionable meaning, he is plagued by the following questions:

1) If I explain the situation to the patient, is he the sort who would conclude there is something "wrong" with the prescription and that perhaps the doctor had made a mistake?
2) Or would he conclude that the pharmacist was "unable to read" the prescription?
3) If the doctor cannot be reached, what honorable yet practical way is there of handling this situation?

The answer to number three is this: There is no practical decent solution to this situation

The solution to the "BID-TID" type of problem (above) is very simple . . . ALWAYS BLOCK-PRINT THE SIGNA, thus:

Sig: ÷ BID, Sig - TTID

and the rest likewise:

QID, QD, PM, PRN, HS

tid (a real trouble-maker) has no traditional justification if used to mean four times daily.

The problem of contacting the doctor has become immeasurably more acute since the passage of the Durham-Humphrey law in 1952. Most doctors do not realize how many drugs that were formerly refillable are covered by this law. Outstanding examples of these are thyroid, digitalis, the amphetamines, the anticholinergics, and practically all the antihistamines made by the large drug houses, and the cortisones and cortisones derivatives *AND THEIR OINTMENTS*. It happens every day in this writer's pharmacy that a patient comes in to say the doctor "told" her to get more of her tablets and that she "doesn't need a prescription." If the druggist calls the doctor in the face of this assurance, the patient feels that her word has been challenged. The point is more clear-cut in the case of samples: doctor gives patient sample and tells her that if they help her she should get more. She shows up at the pharmacy and is told a prescription is necessary. She accuses pharmacist of seeking an excuse to charge more. In each of the foregoing instances a simple step would grease the wheels of progress: when writing prescriptions it is a good idea to authorize at least one refill on the face of the prescription (or mark it "non-rep"); and when giving out a sample, it is a good idea to give a written prescription with it.

SUMMARY: Give complete name, address, and age; print signa; always include all possible information on branded items (strength, maker, coating, etc.), indicate number of authorized refills; give a prescription with all samples.

Board of Medical Examiners

Reregistration of Physicians Possessing Maryland Medical License

THIRTY-NINE STATES require reregistration of physicians. Maryland joined their ranks when the last legislature passed the Reregistration Law, which amends the Law Regulating the Practice of Medicine in Maryland. This law was signed by Governor Tawes and becomes effective June 1, 1960.

All physicians who possess a license to practice medicine and surgery in Maryland who have not received a registration application from the Board of Medical Examiners of Maryland by September 1, 1960, should notify the office immediately. This includes those physicians living out of state who possess a Maryland license to practice medicine and surgery and who wish to keep their Maryland medical license active.

A BILL
ENTITLED

AN ACT to add a new Section to Article 43 of the Annotated Code of Maryland (1957 Ed.), title "Health," subtitle "Practitioners of Medicine," said new Section to follow immediately after Section 129 of said Article and to be known as Section 129A, requiring persons holding licenses to practice medicine and surgery to register triennially and providing fee and penalty.

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That a new Section 129A be and the same is hereby added to Article 43 of the Annotated Code of Maryland (1957 Ed.), title "Health," subtitle "Practitioners of Medicine," to follow immediately after Section 129, and to read as follows:

129A. Every person holding a license to practice medicine and surgery in Maryland shall triennially, before the 1st day of October, 1960, and every three years thereafter, register his name, license number, the school of medicine of which he is a graduate, year of graduation, his office address, telephone number, and state whether he is in active practice, on a form furnished by the Board of Medical Examiners, and he shall pay a fee of Five Dollars ($5.00) for such registration. A certificate of registration shall be issued by the Board triennially to each person registering as herein required. Any person failing to register in accordance with the requirements of this section shall be guilty of a misdemeanor and, upon conviction, shall be fined not more than Twenty-five Dollars ($25.00).

Sec. 2. AND BE IT FURTHER ENACTED, That this act shall take effect June 1, 1960.

Frank K. Mattis, M.D., Secretary
Board of Medical Examiners of Maryland

At the head table, left to right: Albert G. Warfield, speaker, Mrs. Lloyd R. Meyers, Mrs. Thomas F. Lewis, M.D., Mrs. Leslie E. Daugherty.

MEDICAL SOCIETY MEMBERS ENTERTAINED BY AUXILIARY

ALLEGANY-GARRETT County Medical Society members were guests of the Woman's Auxiliary at a dinner meeting held at the Ali Ghan Country Club, Cumberland, in April. The speaker for the evening's entertainment was Albert G. Warfield, vice president of Merrill-Lynch, Pierce, Fenner & Smith, who spoke on "Investments." Thirty physicians and their wives were present.

Left to right: William A. VanOrmer, M.D., Mrs. Emmett Jones, James P. Hallinan, M.D., Mrs. Earl R. Paul, Earl R. Paul, M.D., Mrs. James P. Hallinan, Emmett L. Jones, M.D., Mrs. W.A. VanOrmer.

Left to right: Mrs. Abdul S. Hashim, Mrs. Wyand F. Doerner, Mrs. Gina Glick, Wyand F. Doerner, Jr., M.D., Robert Feddis, M.D., Mrs. Robert Feddis, Mrs. L. B. Ransom, Leland B. Ransom, M.D., Abdul S. Hashim, M.D.

Personals

GINA PHILLIPS GLICK, M.D., Cumberland, has been named to active membership in the American Society of Anesthesiology.

Wyand F. Doerner, Jr., M.D., addressed the Nurses' Alumnae of Sacred Heart Hospital, in Cumberland, on "Emphysema."

Leslie E. Daugherty, M.D., presided at the Regional Conference On Aging, held in Baltimore March 30-31. The conference was sponsored by the American Medical Association and the state medical societies of Delaware, Maryland, Virginia, New Jersey, West Virginia, and the District of Columbia.

As a part of the observance of National Mental Health and Hospital Week, Ton van Strien, M.D., and Arthur F. Jones, M.D., Allegany-Garrett County health officers, participated in a panel discussion at Springfield State Hospital. The panel topic was "The Mental Hospital and the Community—A New Team."

E. Irving Baumgartner, M.D., Oakland, who serves as a vestryman, was recently elected a senior warden of the Saint Matthew's Episcopal Church. Another physician, R. Rhett Rathbone, M.D., is serving a three year term on the vestry of the Emmanuel Episcopal Church, in Cumberland.

C. C. Zimmermann, M.D., Cumberland, is vacationing in Tahiti, New Zealand, Australia, Fiji, Samoa, and the Hawaiian Islands.

R. Rhett Rathbone, M.D., recently presented an illustrated talk on cancer before the Future Nurse's Club of Allegany High School, in Cumberland. He demonstrated the functions of the radioisotope machine in the treatment and detection of cancer.

At a Ladies Night meeting of the Lonaconing Rotary Club, Abdul Hashim, M.D., Cumberland, told about "Family Life in Iraq."

Physicians attending the 162nd Annual Meeting of the Medical and Chirurgical Faculty, in Baltimore, were: Carlton Brinsfield, M.D., W. Royce Hodges, M.D., Leland B. Ransom, M.D., Thomas F. Lusby, M.D., Wylie M. Faw, Jr., M.D., Earl R. Paul, M.D., Robert Feddis, M.D., Benedict Skitarelic, M.D., all of Cumberland, and E. Irving Baumgartner, M.D., of Oakland. At the presidential dinner, Leslie E. Daugherty, M.D., retiring president of the Faculty spoke on the "Economics of Medicine."

W. O. McLANE AND W. R. HODGES ELECTED TO FACULTY OFFICES

W. Oliver McLane, Jr., M.D., of Frostburg, was elected a vice president of the Medical and Chirurgical Faculty of Maryland, and W. Royce Hodges, M.D., of Cumberland, has been elected a councilor to represent Western Maryland on the Council for the next three years.

BIRTHS

Mildred (Sheesley) Wagner, M.D., and George W. Wagner, of Westernport, announce the birth of a son, George Wayne, on March 5.

A daughter, Sheila, was born to Dr. and Mrs. Robert Feddis on April 4 in Cumberland.

AMERICAN COLLEGE OF CHEST PHYSICIANS

The American College of Chest Physicians will hold its 26th annual meeting, June 8-12, 1960, in Miami Beach, at the Saxony Hotel. Seymour M. Farber, M.D., San Francisco, president of the College, will preside. M. Jay Flipse, M.D., Miami, will succeed Dr. Farber as president at the conclusion of the Presidents' Banquet on Saturday, June 11. Alexander Libow, M.D., Miami Beach, is chairman of the Committee on General Arrangements.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.
Journal Representative

A SPECIAL MEETING of the Baltimore City Medical Society opened the session on Friday, April 1, 1960. After the pertinent part of the minutes of the preceding meeting were read, stating the purpose for which the meeting was called, the Bylaws amendment specifying 50 members as a quorum was unanimously passed.

The proposal of the Nominating Committee that Charles Wainwright, M.D., be named president-elect was unanimously approved; no other nominations were offered. Concluding these two actions, the special meeting was adjourned and the semiannual business meeting was called to order.

Like a board of directors, the hard core of approximately 100 interested individuals proceeded to direct the business affairs of the Society. Minutes were read and approved, and new members were proposed and accepted.

President Diggs took a few minutes to clarify his statements regarding the Committee to Investigate the Admission of Private Patients to Baltimore City Hospitals made at the last meeting. He regretted that anything in his previous remarks might have been considered derogatory. Since that meeting he had had an opportunity to read the newspaper accounts for himself and wanted it clearly understood that he had no complaints regarding the committee's actions.

Resolutions for presentation to the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland were reviewed. Probably the most thoroughly discussed item was a resolution from the Faculty Veterans' Medical Care Committee to abolish the Dean's Committees for Veterans Administration hospitals. William S. Stone, M.D., speaking extemporaneously on behalf of the Dean's Committee of Baltimore, declared the resolution as worded did not accomplish its purpose. Initiation of Dean's Committees was intended to enlist the help of medical schools in veteran care and to raise the standard of that care. He assumed all doctors want veterans to get good medical care. Dean's Committees, as well as anyone else, he said, are opposed to the use of Veterans Administration hospitals for non-service-connected disabilities.

Past President Amos Koontz gave some background of the Resolution. "Empire building," frankly admitted by high officials in the Veterans Administration, has become detrimental to civilian hospitals, he declared, adding, "The Dean's Committees only give academic status to this evil." By removing so many physicians from civilian practice and so many nurses from availability in civilian hospitals, VA hospitals were "wreaking untold havoc to the private practice of medicine and taking an active part in the creeping socialism that besets our country."

Samuel Morrison, M.D., urged members not to throw a stranglehold on veterans' medical care. He believed that veterans' organizations which "can get anybody in," are largely responsible for the high census in veterans hospitals. He further reported that some family physicians insist that

patients be admitted to the Veterans Hospitals, even though they are able to pay.

Ernest Cornbrooks, M.D., told that in his ten years as a consultant to two veterans hospitals, he had seen but one service-connected disability in his field of gynecology. "It is time to stop this farce." Impossible as it may seem to sift out service-connected from non service-connected disabilities, our great tax cost mounts from the providing of free medical care for non-service-connected illness to veterans who can afford to pay.

Dean Stone reiterated his opinion that the Dean's Committees were responsible only for the *quality* of medical care, and they have nothing to do with the question of service- or non-service-connection of disability. Fully opposed to non-service-connected disability care in veterans hospitals, he felt that this resolution is not the way to end the problem.

Dr. Koontz charged that all discussants were begging the question; it is not the responsibility of the Government to furnish teaching centers to attract residency training for the care of non-service-connected disabilities. All the eligible veterans are, by now, chronic cases and of little interest to the residency-training programs. Such large residency training staffs create the demand for acute illness to treat, which demand causes the high admission of non-service-connected patients able to pay. Furthermore, it is not right for the Government to compete with medical schools in setting up residency-training programs. The Medicare system in Dr. Koontz's opinion, is much better; veterans should be treated in their local communities. The whole system of socialized medicine, as exemplified by Veterans Administration hospitals, is wrong. "We ought not to support something that is wrong."

The voting was close, but by a standing vote, the resolution was supported 60 to 41, prompting the query from John W. Scott, M.D., whether this outcome was to be considered an instruction to the delegates. President Diggs quoted from Robert's Rules of Order that delegates were bound to vote as the society votes only on resolutions *originating within the society.* Since this resolution had not originated within the City Society, its delegates were not bound to vote for it; however, the sentiments expressed at the meeting should certainly be given due weight by the delegates to the Faculty meeting in reaching their own decision.

After discussion of another resolution, an amendment was attached calling on the delegates to vote as the City Society voted. Delegate William Grose, M.D., rose

Newly Licensed Physicians

At a reciprocity meeting on April 19, 1960, the Board of Medical Examiners licensed the following physicians to practice medicine and surgery in Maryland:

Bouma, John Henry, Minnesota
Brodell, Robert David, Ohio
Campbell, Colin, National Board
Christy, Ralph Lawrence, Jr., Colorado
Cooke, Charles Robert, National Board
Day, Harry Luther, National Board
Drabkin, Bernard, National Board
Duke, Clarence James, District of Columbia
Eidelman, Mildred Greenberg, National Board
Eisenlohr, John Edward, Texas
Gatti, Dominic Louis, Pennsylvania
Hamburg, David Alan, Indiana
Hilkert, Fred George, National Board
Holland, James Meyer, National Board
Lee, Shun Tsang, National Board
Schaengold, Richard, Ohio
Van Wageren, Nan Poppell, National Board
Wilhelm, Frederick Henry, National Board
Wilkes, John Daniel, National Board

in protest against an "instructed" delegation, asserting that delegates who are interested in medicine and are expected to be capable of their own judgment should be allowed to use it and not be bound by the will of others. Other members spoke in agreement; none favored the idea of sending an instructed delegation. A voice vote vetoed the instruction of delegates on this resolution and, by implication, on the other resolutions considered.

Despite the declaration of Howard Jones, M.D., chairman of the Faculty Committee for Liaison between the Faculty Accreditation Committee and the Medical Facilities of Maryland, that a resolution critical of the AMA Residency-Review Committee was unnecessary, duplicative, and potentially confusing, the resolution was passed by a vote of 61 to 30. Voice votes favored a resolution to reverse the trend of taking student nurses away from the bedside and another to protect physicians from law suit after providing emergency care to individuals. Lack of clarity in the wording of a resolution on adoption procedures was pointed out. Dudley Babb, M.D., said that the lack of clarity was not intended and could be worked out.

Amendments to the Faculty Constitution and Bylaws were read and reviewed. The differential in fees was discussed, but no action voted; there seemed to be continued confusion as to its content.

A delegates meeting was held with some members of the Executive Board, at which time Raymond C. Vail Robertson, M.D., was elected chairman of the City delegates group. President Diggs reaffirmed obligation of the delegates only to resolutions originating with the City Medical Society; however, they should heed the views expressed during the meeting regarding other resolutions and exercise their best judgment. Further discussion took place about membership fee differentials, reasons for which they were not particularly clear, and on the proposed emergency care protection legislation.

Coffee and doughnuts were served by Walter and Ellen. Absence of our favorite Auxiliary has been noticed.

Favorable comment was heard about the new meeting reminders, since George H. Yeager, M.D., chairman of the Program Committee, has arranged for the strategic placing of signs announcing the meetings. Conspicuously posted in the hospitals at points where doctors gather, the signs help to raise the academic level of meeting attendance. Where can they be placed to raise the practitioner titer?

★

CHARLES W. WAINWRIGHT, M.D., new president-elect, was welcomed at the Executive Board meeting on Tuesday, April 5, 1960. The first order of business was to decline a request for contributions to the National Society for

RESOLUTIONS

Medical and Chirurgical Faculty

All resolutions to be presented to the House of Delegates at its meeting on Friday, September 16, 1960, *must* be in the Faculty Office, 1211 Cathedral Street, Baltimore 1, *no later* than Friday, July 22, 1960.

Medical Research, an action which falls under the general policy that by contributing to one worthy organization, we would have to contribute to them all. In this instance, our members contribute individual support.

Robert Kimberly, M.D., and John Tilden Howard, M.D., were reappointed to the Coordinating Council for Fund-Raising Campaigns. Both have served well in the past two years, and it was felt that their experience should remain for another term.

The Grievance Committee, a subcommittee of the Executive Board, was severely taken to task by an angry physician. Challenged by a labor organizer, the physician was grieved by the Grievance Committee's apparent failure to support him. The committee had written, suggesting that he change his policy, sending copies of the letter to both parties. The then chairman of the Grievance Committee insisted that the letter written was justified by the facts at hand at that time. The physician felt that he had been betrayed and abandoned by the very organization that should have supported his good reputation by giving him the benefit of the doubt. That the labor organizer had apologized upon finding the facts to be as the doctor had stated plus the fact that the matter had been settled made no difference in the physician's concept of the principles at stake. The attitude that we should all take, Grievance Committee included, is obviously the old service one that: "All the brothers are courageous and all the sisters virtuous," if we are to present a united front against our adversaries.

Another aspect of Grievance Committee problems was the announcement by one of the quarterly chairmen that his automobile had been broken into, with several folders full of Grievance Committee matters stolen and not recovered.

Samuel Morrison, M.D., called attention to the fact that no replies had been received from the Board of Medical Examiners regarding the right of chiropodists to prescribe potent systemic medicines, such as steroids and antibiotics. Previous minutes of the Executive Board were reviewed for dates of other matters brought to the attention of the Board of Medical Examiners to which no reply had been received. A reason for such lack of response is to be sought. If it is legal for chiropodists to prescribe hazardous medicines, we can stop being outraged and quit annoying the Board of Medical Examiners with our fact-finding; but we want to find out.

A letter to the Society from Mrs. Stuart Sunday, safety chairman of the Woman's Auxiliary to the Baltimore City Medical Society, concerning "Accident School for Mothers and Dads," attracted the interest of the Executive Board members in the far-reaching implications of our Auxiliary's activities. President-elect Wainwright expressed himself as appalled at the enormity of the program. This and other activities are to be discussed with the Executive Committee of the Woman's Auxiliary when it meets with the Advisory Committee of the City Society.

Russell Fisher, M.D., treasurer, reviewed the status of delinquent members. Those who are delinquent because of moving away, illness, and just plain failure to pay dues were considered individually. Appropriate action was directed.

Physicians Defense to individuals who are not active members and to active members who do not pay dues on time has caused some confusion, because of the recent change in definitions of active and associate membership. This problem is to be referred to the Committee on Constitution and Bylaws.

A letter opposing federal legislation that leads to socialized medicine and advocating that organized medicine support candidates who oppose such legislation was reviewed. It was recognized that

our Society's tax exempt status depends on our advocation of principles and not persons. It was, therefore, reluctantly decided to advise the correspondent that, while we thoroughly agree with his viewpoints, we can only support principles, not candidates. We certainly are against socialized forms of medicine at any level!

BALTIMORE COUNTY MEDICAL ASSOCIATION

WILLIAM H. F. WARTHEN, M.D.

Journal Representative

THE MEETING OF the Baltimore County Medical Association, Inc., was held at 1:00 P.M. on Wednesday, March 16, 1960 at Longley's Restaurant in Towson. President J. Morris Reese presided. After luncheon the meeting was called to order, and the minutes of the February 18 meeting were approved as published.

William Conway, M.D., and John J. Darrell, M.D., were approved for active membership in the Association.

William H. F. Warthen, M.D., deputy state and county health officer, introduced Colonel John W. Welch, director of medical services of the Maryland State Civil Defense Agency. Colonel Welch outlined briefly the history of the civil defense program and explained that the purpose of his visit was to request the Association to appoint a committee to select a physician to serve as a reserve officer with county officials on the civil defense program. This physician will be required to attend the Civil Defense Training Center in New York from April 18 to 23. The motion was carried to appoint a committee to study and make a report to the members on how the civil defense program in Baltimore County could be strengthened.

At the conclusion of the business meeting, Dr. Reese and Dr. Charles F. O'Donnell reported on the activities of the Advisory Board of Health of Baltimore County. Both doctors are physician members of the eleven-member Advisory Board of Health, of which Dr. Reese also serves as chairman. Dr. Reese included in his report background information on the formation of the Advisory Board of Health, its method of operation, and the recommendations which have been made by this group up to the present time. Some of the pertinent facts discussed by Dr. Reese are noted as follows:

The County Council, comprised of seven elected individuals, functions also as the County Board of Health. The Baltimore County Health Department is governed by the decisions of this Board of Health if the decisions are not in conflict with those of the Maryland State Health Department. In 1957 the County Council authorized a survey to be made of the program of the Health Department by The Johns Hopkins School of Hygiene and Public Health under the direction of Ernest L. Stebbins, M.D. The results of this survey, which was most comprehensive and included many recommendations, were made known to the Board of Health in April of 1958. One recommendation of the Stebbins Report was the creation of an Advisory Board of Health, which body was appointed by the Board of Health on May 5, 1959. In line with Dr. Stebbins' recommendations, several committees have been appointed by the Advisory Board of Health, and these are now functioning. In October, 1959, after numerous committee meetings, recommendations were made to the Board of Health by the Advisory Board of Health. The Advisory Board of Health has no authority to take any final action upon the health program of Baltimore County, but it can make recommendation to the Board of Health, which has the legal authority to act in matters of health.

One of the functions of the Advisory Board of Health is to study and make recommendations concerning the Health Department budget. This group recommended that the 1960 budget be accepted as submitted by the deputy state and county health officer; however, the budget was cut by one-third. This is considered to be inadequate to provide all the services a health department working with a population as great as that of Baltimore County should have.

Dr. O'Donnell elaborated on Dr. Reese's statements by outlining specific situations which the Advisory Board of Health is studying at the present time. He commented that, although at times there existed differences of opinion among the members of the Advisory Board of Health, on most issues a final decision was made on a vote of 9 to 2.

All present enjoyed the presentations of the two physician members of the Advisory Board of Health.

MONTGOMERY COUNTY MEDICAL SOCIETY

CHARLES FARWELL, M.D.
Journal Representative

PUBLIC SPIRITED members of our group continue to donate their time and efforts toward educating the people in our community on intelligent use of available medical services. Among those doctors deserving credit for speaking on topics of medical interest are: Merrill M. Cross, M.D., on "Heart Attacks" to the Silver Spring Board of Trade; J. A. Roberts, M.D., on "Cancer" to the Forest Knolls Civic Association and on "Heart Attacks" to the Bethesda Junior Chamber of Commerce. Other doctors speaking on "Heart Attacks" to various groups were: George Sharpe, M.D., to the Optimist Club of Wheaton; Jason Geiger, M.D., to the Exchange Club of Silver Spring; Sarah Elizabeth Glover, M.D., to the Keating Club of Rockville; Howard T. Morse, M.D., to the Community League of Takoma Park; and Charles J. Savarese, M.D., to the Bethesda Civitan Club. Bernard H. Ostrow, M.D., spoke on "Newer Conceptions in Coronary Disease" to the Kiwanis Club of Silver Spring; E. L. Marston, M.D., on "Diagnostic Methods and Surgical Approaches in Cardiac Surgery" to the Professional Nurses Club of Suburban Maryland; Bernard Murphy, M.D., on "Adolescent Problems" to the Episcopal Church in Bethesda; Sarah S. Tenenblatt, M.D., on "Emotions and Learning" to the Radnor Elementary School PTA, Bethesda, on "Tensions" to the Ladies' Auxiliary of the D. C. Pharmaceutical Association, and on "Discipline: How Much and When" to the Oakland Terrace Elementary School PTA; Charles I. Warfield, IV, M.D., on "Uterus and Breast Cancer" at the Woodward & Lothrop Auditorium, Wheaton.

"Cystic Fibrosis of the Pancreas" was the scientific subject presented by Paul di Saint Agnese, M.D., at our dinner meeting. Featured was an up-to-date outline of diagnosis and treatment of this disease, which will be seen more as we look for it.

Colonel J. E. Ash, M.D., and Edward C. McGarry, M.D., were hosts to the Maryland Society of Pathologists meeting at Suburban Hospital. Robert D. Solomon, M.D., of Sinai Hospital in Baltimore presided. Personal observations on pathology in the Soviet Union by John H. Edgecomb, M.D., was a highlight of the scientific program.

FRIDAY, SEPTEMBER 16—SEMIANNUAL MEETING
COMMANDER HOTEL, OCEAN CITY

WASHINGTON COUNTY MEDICAL SOCIETY

GEORGE JENNINGS, M.D.

Journal Representative

The Washington County Medical Society held its regular dinner meeting March 24, 1960, at 6:00 P.M. in the Venice Restaurant. After the dinner, a special program was presented on "Doctors Prepare for Retirement." Mr. Wilbur King, of the Social Security office of Hagerstown, discussed the history, costs, and benefits of the Social Security program. Mr. Lynn Schmidt considered the advantages and disadvantages of Social Security as compared with life insurance, and Mr. Charles Brown contrasted Social Security with investments. W. T. Layman, M.D., then discussed the Jenkins-Keough Bill.

The new law concerning the examination of persons suspected of driving while under the influence of alcohol and the test required was explained by J. H. Beachley, M.D., police surgeon.

Ross V. Cameron, M.D., Washington County public health officer, made a motion to take steps toward re-establishing the communication and good will that once existed between the health department and the Washington County Medical Society.

WICOMICO COUNTY MEDICAL SOCIETY

GLADYS M. ALLEN, M.D.

Journal Representative

At the April meeting of the Wicomico County Medical Society, a panel discussion was held on the various approaches to the treatment of psychoses. Panel members were Walter Weintraub, M.D., assistant professor of psychology at the University of Maryland School of Medicine and chief of the inpatient department, and William Wheat, M.D., assistant professor of psychology at The Johns Hopkins University School of Medicine and senior resident on Phipps Institute staff. The discussion was moderated by Alfred S. Ledermann, M.D., of Salisbury.

A routine business meeting was then held to consider various items chiefly of interest to the Washington County Medical Society.

On March 12, 1960, the Washington County Medical Society lost another member in the death of O. H. Binkley, M.D. Dr. Binkley had been ill for several years. Until his illness, he had been active on the staff of the Washington County Hospital and in the affairs of the medical society, both on the local and state level. He will be missed by all who knew him.

Seventh Annual Meeting of The Society of Nuclear Medicine Stanley Hotel, Estes Park, Colorado June 22-25, 1960

More than 70 speakers will divulge new scientific information covering every phase of research, medicine, and surgery pertaining to the use of nuclear phenomena in the diagnosis and treatment of disease. Special emphasis will be given to the diagnosis and treatment of thyroid disease, therapeutic use of radioisotopes and "tools of the trade."

The first annual address of the Nuclear Pioneers Series, in honor of the late Ernest O. Lawrence, M.D., will be delivered by Edward Teller, M.D., of the University of California.

The meeting is open to all physicians, veterinarians, nurses, physicists, technicians, and other scientists working with or interested in utilizing radioisotopes in the health field. There is a nonmember registration fee of $5.00. Registration forms and copies of the program may be secured by writing to Mr. Samuel N. Turiel, Administrator, The Society of Nuclear Medicine, 430 N. Michigan Avenue, Chicago 11, Illinois.

Maryland
SOCIETY OF PATHOLOGISTS INC.
ROBERT SOLOMON, M.D., *President*
EDWARD C. MCGARRY, M.D., *Secretary*
Suburban Hospital, Bethesda, Md.

The Teaching of Pathology To Sophomore Medical Students At the University of Maryland

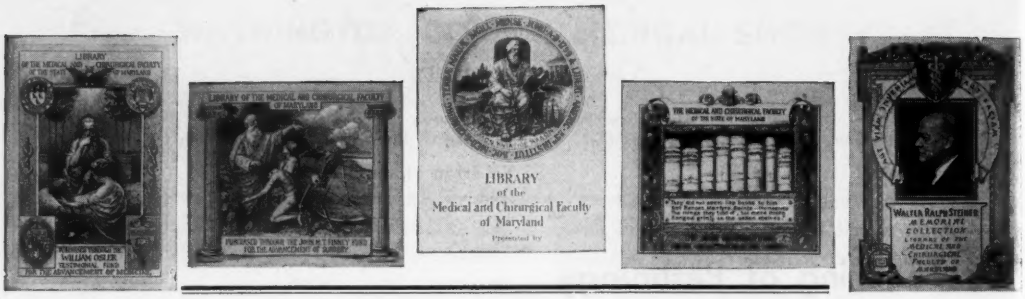
SEVERAL MODIFICATIONS of classic teaching methods are being used at the University of Maryland. Emphasis is placed on the "case method" of presenting autopsy material. Autopsy cases consist of the preserved organs, representative microscopic slides, and a summary of the patient's clinical course. The cases are selected by the staff and correlated with the particular subject being considered in lectures and laboratory. A student studies the case and presents to a small group of classmates the clinical summary and demonstration of the gross and microscopic features, relating the autopsy findings with the signs and symptoms observed clinically. The instructor directs the discussion, emphasizing pathogenesis.

Another group discussion is devoted to fresh autopsy case material. The gross changes are emphasized and correlated with the clinical summary.

An experimental laboratory period is also included in the course. Certain fundamental pathologic processes produced in experimental laboratory animals graphically teach the sophomore student that disease is dynamic and changing. This once again shows him the importance of understanding all stages in the evolution of the disease process.

Work in the experimental laboratory stimulates additional interest when the student is allowed to design and execute an original experiment. These experiments, although limited by available time and facilities, teach developing physicians the enormous attention to detail required to evolve new facts concerning disease.

It should be indicated, however, that the modifications mentioned have not eliminated traditional teaching methods. Attendance at the autopsy dissection is still required, but again, emphasis is placed on pathogenetic sequence and clinical correlation when the student presents his case to a group of his classmates. The isolated museum specimens, the microscopic slide loan set, and the formal lectures are still very much a part of the course at the University of Maryland. It is recognized, however, that today's medical education requires close scrutiny by the student of the etiologic factors and the sequential pathogenesis of disease states. He must relate in his mind's eye the changes he sees at the autopsy table to changes taking place during the course of disease in a living patient. The recognition of such relationship is sought in the course at the University of Maryland.



Library

Louise D. C. King, *Librarian*

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *Ibn Tibbon*

TOOLS

"Man is a tool-using animal . . . Without tools he is nothing, with tools he is all."

Sartor Resartus, Thomas Carlyle

EVERY TRADE, art, or other occupation has its own tools, things essential to the carrying-on of the work. Libraries and users of medical literature are no exception to this rule. There are many indices, bibliographies, and other reference works to aid us in one or more facets of search; but we shall mention here one or two tools which will enable us to keep abreast of the literature or to delve superficially into the older contributions.

Although a physician's office may have a medical dictionary—and it should be a recent one—the secretary should be cognizant of its scope. The library is often called for the definition of a syndrome or for information about a test, a disease, or a reaction, which information might easily have been found in such a volume.

There are few doctors who subscribe to the *Index Medicus,* but we can think of no better investment than the $20.00 per year which would bring him a monthly index of world wide medical literature. The *Index Medicus* is arranged by author and subject, the latter detailed enough to show what has been written on almost any phase of medicine in which you might be interested. With a yearly cumulative index, you would have a tool that never entirely loses it usefulness and one of far more value than textbooks amounting to an equal sum of money, since the textbooks become obsolete almost as soon as they are printed.

You should also familiarize yourself with former indices which are in your library: the old *Index Medicus* from 1879 to 1926-27, the *Quarterly Cumulative Index Medicus* from 1916 to 1956, the *Current List of Medical Literature,* which ran from 1941 to 1959, and in 1960 the best of all, the new *Index Medicus.* For older literature, there is nothing comparable to the *Index Catalogue,* which gives in its four series, not only the holdings of what is now known as *The National Library of Medicine,* but also indexes by subject, the contents of its journal holdings. You are, therefore, able to obtain bibliographies of texts and journal articles on a given subject embracing a span of years. This is an indispensable tool for historical and source material not in the yearly volumes of its acquisitions issued since 1955, as journal articles are not included.

You should make yourself thoroughly conversant with these books, what they can or cannot do for you. It is well to remember a few pertinent facts about them. The journal indices, due to insurmountable obstacles, are apt to be several months behind in indexing journals. This is particularly true of foreign periodicals. When you require the most recent references, you will find they have not yet been included in the last monthly index. It is also well to remember that the subjects under which articles are listed are bona fide terms or phases of medicine. If you ask for a syndrome, it must be a specific one, not

one which may be found in a host of diseases or conditions; and, if you need a reference on a specific disease, be sure the term is correct or, at least, that your searcher is given sufficient information to recognize the subject when the term given is not mentioned. If you are doing the searching yourself, it is a different matter, although even then you may not know under what subject the article may be listed. It is then well to consult with your librarian for possible assistance. Statistics of a condition are one of the most difficult things to find, because there may be no indication in a title that statistics are included, and, unless the whole article deals with statistics, it may not be indexed under that subhead. Another almost impossible task is to find an exact duplication of cases. More often than not, this type of reference question requires reading through many articles which might mention such a case, together with others of a similar nature. This work is much too time consuming for your librarians to undertake.

The *Index Catalogue*, 1880 to 1955, it is well to note, changes its terminology from year to year. The earlier and later volumes may list articles of a like nature under totally different headings.

Libraries do, of course, have many other tools used in research, but if every physician were thoroughly acquainted with those mentioned above, his own work would be made easier and librarians would no longer be asked to do the impossible. We should be glad to show you these tools and guide you toward understanding their uses. We feel sure you will be amazed at their comprehensiveness and value, if you do not tire of the tediousness first. Reference work is time consuming, tedious, and, at times, hard on the temper, but it is rich in its reward of work well done.

Even the marvelous reference tools at the disposition of librarians have their limitations. It is that sixth sense, intuition, or what you will, of where, when, and what to use that marks the good reference librarian.

MARYLAND TUBERCULOSIS ASSOCIATION
Christmas Seal Agency for State of Maryland
900 ST. PAUL STREET • BALTIMORE 2, MARYLAND

NEW TB PROGRAMS VIA A CONFERENCE ON AGING

Claudia Galiher, Executive Director, Montgomery County Tuberculosis and Heart Association

Joseph A. Papsidero, Assistant and School Health Director, Montgomery County Tuberculosis and Heart Association

William J. Peeples, M.D., Medical Officer, Montgomery County

Mrs. T. C. Gordon Wagner, Representative Director, Montgomery County Tuberculosis and Heart Association to the Maryland Tuberculosis Association

THE MONTGOMERY and Prince George's Counties' regional Conference on Aging, held at the clinical center of the National Institutes of Health in Bethesda on January 20, 1960, was the first of a series of regional conferences to be held in Maryland. This conference was planned jointly by the Maryland State Commission on Aging and a group representing local, official, voluntary, and civic agencies. Among the group of cooperating agencies was the Montgomery County Tuberculosis and Heart Association, which derived a number of possibilities for developing educational and service programs for older people.

The conference, under the chairmanship of the Honorable Margaret C. Schweinhaut, chairman of the State Commission on Aging, was planned as a pilot project for others to follow. It certainly set the pace! The sponsors did their work so well that an attendance of 750 persons was recorded, far exceeding the most optimistic estimates, and all facilities were overtaxed.

HEALTH AND MEDICAL NEEDS EXPRESSED

Five individual workshop groups, Health and Social Services, Use of Leisure Time, Housing, Sources of Income, and Employment and Vocational Rehabilitation, met for the discussion of many aspects of their respective subject areas. Especially popular was the workshop on Health and Social Services, led by William J. Peeples, M.D., Montgomery County health officer, and Murray Grant, M.D., Prince George's County health officer. This group explored a number of questions related to existing services and needs; such as: Are general and chronic hospitals being used for the purpose for which they are intended? What should be the role of the nursing home in meeting the demands of older people? How effectively are health, medical, and social needs being met at home? What specific approaches are necessary to a positive program of health for the aging? Discussion also covered a range of services: hospitalization, rehabilitation, physical therapy, dental care, dietetics, vision, hearing, orthopedics, psychiatry, and individual and family counseling.

An important product of the pre-conference deliberations, as well as the workshop recommendations on Health and Social Services, were a number of suggestions for program development of interest to the Tuberculosis and Heart Association. These are:

1. To assist in meeting the needs for coordination of home care services. A goal of this program would be to establish a central referral source for

physicians and others who need information. On referral from a physician, a social worker could counsel families and assist the physician in obtaining such services as nursing care, occupational therapy, physiotherapy, and homemaker services for patients.

2. To explore the possibility of establishing a homemaker service program whereby trained homemakers can go into the home to assist patients. This service would also require that a training program for homemakers be established.

3. To help establish a training program for occupational therapy assistants, which would provide nursing homes with adequately trained people to carry on O.T. activities (under supervision). The Association has already provided assistance by helping to obtain a grant for establishment of such a program in Montgomery County.

4. To explore the possibility of initiating volunteer programs in nursing homes on a demonstration basis.

5. To carry on and further expand the occupational therapy demonstration program, which the Association has offered to nursing homes as a way of demonstrating the value of O.T. services.

6. To further explore and assist, in any way possible, in establishing and carrying on preventive care programs and to assist nursing homes in improving their own care programs.

7. To establish a family education program aimed at patient and family counseling.

Senator Pat McNamara, chairman of the United States Senate Subcommittee on Problems of the Aged and Aging, presented a Declaration of Rights for Older Americans, which includes 10 points:

Older Americans should have a right to expect, in retirement, an opportunity to continue the same standard of living they enjoyed during working years. And they are entitled to protection of their purchasing power during retirement.

The aged of the United States have a right to equality in the highest standards of health and medical facilities and the full range of many new possibilities in this field.

Older citizens are entitled to a floor of real *financial protection from the increasing hazards of poor health and the high cost of medical care.*

The aged are entitled to benefit more rapidly than is now possible from the proven results of research on aging in our universities and government agencies.

They are entitled to live as independent human beings in housing arrangements of their own choosing, protected from the slum-creating process now blighting the cities.

The increasing numbers of aged persons, who need care they cannot get in their own homes, are entitled to expect high standards of nursing homes, and other such facilities, to provide them with a human and not a vegetative existence.

Ability and not age should be the major factor in deciding whether or not a person should be employed, especially those under the age of 65. Equally important, the older worker has the right *to retire with adequate retirement preparation after contributing for 40 or 50 years to the wealth of the economy.*

Senior Americans should expect encouragement to participate in the general activities of their communities suitable for mature men and women and not be exiled to the rocking chair and frivolous activities to pass away the time.

Older citizens are entitled to have a coordinated community or government agency focused on their special needs and problems in place of the dozens of disconnected agencies existing now in many localities.

Finally, in the securing of these rights, there should be a guarantee of the right of older people to free choice, self-help and the planning of their own lives.

The Maryland Society of Anesthesiologists has elected the following officers for the ensuing year:

President: Donald W. Benson, M.D.; President-elect: Martin Helrich, M.D.; Treasurer: Paul R. Hackett, M.D.; Secretary: Otto C. Phillips, M.D.; Delegate to the A.S.A.: Thomas J. DeKornfeld, M.D.

Blue Cross - Blue Shield

BLUE CROSS-BLUE SHIELD AND THE OLDER PERSON

Denwood N. Kelly*

WITH INCREASING INTEREST in Forand type legislation to provide for the medical care of various segments of our older population at government expense, it might be well to review briefly how Maryland's senior citizens may presently be protected against the cost of illness through Blue Cross-Blue Shield.

Since the inception of our plans, there has been a steady increase in activities toward the enrollment of older people, even though these persons constitute a much costlier type of risk. Blue Cross-Blue Shield have always permitted subscribers to continue their coverage past age 65; but, initially, the plans did not accept new applicants beyond that age.

Later the restriction was relaxed to permit these older people to enroll through a group when that group was being formed, but at no other time. Still later, older people who secured employment at an office or plant where a group was in existence also became eligible at their first opportunity to enroll as new employees, but not thereafter. This is the general situation today, and it means that an enrolled person over 65 may be enrolled in a group, without regard to his physical condition, upon his first opportunity to do so. Once he passes up his initial opportunity to enroll, he may not normally do so again through the group (non-group enrollment is still a possibility as will be discussed). This "one time" group regulation is necessary to protect the plans against adverse selection.

As mentioned, people who enroll in Blue Cross-Blue Shield before they reach 65 are not cancelled when they attain that age. Rather, they are encouraged to keep their Blue Cross-Blue Shield when they retire, when they resign, or if their employment is terminated; and a substantial number of them do so. It is the very fact that so many older or chronically ill people keep Blue Shield and Blue Cross when they retire or when their employment ceases that makes it necessary for rates for this so-called "direct-pay" category of membership to be higher than for group subscribers. In this segment of our membership we always have a high percentage of older people enrolled. Part of the higher cost of their care is paid for out of our group subscription income, so that the non-group or direct-pay rates will not be out of reach of the elderly, who normally live on reduced incomes.

Beginning in October 1959, the plans also began to accept applications for non-group (frequently called "individual") memberships from persons over 65, just as had previously been done for those under that age. These applications are subject to careful scrutiny, and each one is individually underwritten, which means that the applicants, regardless of their ages, have to give evidence of being in sufficiently good health so that they will be acceptable as average risks. If a person has some disease which makes him an abnormally poor risk, he may be refused membership. If he has some condition which makes him a substandard, but not completely unacceptable risk, he may be issued a "ridered" membership certificate which excludes benefits for a specific condition. The same criteria are applied to non-group applicants who are under 65, there being no discrimination against the older people in the operation of this phase of our program. Thousands of elderly Maryland citizens have been accepted by Blue Cross-Blue Shield since the non-group programs were opened to them last October.

We realize that this non-group program may be confusing to physicians who supply us with medical information on some of their older patient-applicants and then see their applications refused. It should be remembered, however, that we have to underwrite this program in such a manner that the costlier risks will not unduly penalize the

*Assistant Director, Maryland Medical Service, Inc.

other members of the program. Even with this careful underwriting, the rates for non-group members would be far higher than they are if they were not partially subsidized by the group rate.

All in all, we have about 61,000 persons enrolled who are over 65 at the present time. This is equivalent to about 5.9 per cent of our total enrollment, and as the years go by, both the number and percentage are steadily increasing.

The 14th annual Rocky Mountain Cancer Conference will be held in the beautiful new Denver Hilton Hotel in Denver, Colorado on July 20-21, 1960. Approximately 900 physicians from all over the nation are expected to attend the two-day scientific session, which is worth 10 AAGP Category I Credits.

Physicians Needed for Military Service

The armed forces continue to require the services of most physicians liable for military service under the Universal Military Training and Service Act.

Lieutenant General Lewis B. Hershey, director of Selective Service, issued this reminder to physicians when it became apparent recently that the armed forces would not call to active duty a small number of physicians in a few specialties who had been deferred for residency training under the Armed Forces Reserve Medical Officer Commissioning and Residency Consideration Program.

All reserve officers deferred for residency in most specialties will be called.

Shortages exist and will continue in certain specialties and in the group of officers who have not specialized, according to information received by the Director of Selective Service from the office of Frank B. Berry, M.D., assistant secretary of defense (health and medical).

The Selective Service Director urged physicians not to draw erroneous conclusions concerning the need of the armed forces for their services. If a substantial number of physicians, basing their decision on knowledge that a few reserve medical officers in a few specialties are not being called to active duty after residency, conclude they are not needed, existing shortages in the armed forces will be aggravated.

The Department of Defense has found it unnecessary to requisition physicians through the Selective Service System since early in 1957. This has been so only because sufficient numbers of physicians sought reserve commissions and thus made themselves available for call to active duty.

There is a continuing need for applications for the residency program, as well as for reserve commissions and active duty at the conclusion of internship, General Hershey stressed.

The temporary surplus in some specialties in the residency program is understandable. Estimates of needs must be made four or five years ahead. Other factors are revisions in armed forces strength, redistribution of troops, reorganization of the hospital system, specialists choosing a military career, and voluntary extension of duty tours by reserve officers.

The Heart Page

William R. Scarborough, M.D. — Coeditors — Kyle Y. Swisher, M.D.

A SERVICE OF
THE HEART ASSOCIATION OF MARYLAND

WHAT IS COR PULMONALE?

Bruce W. Armstrong, M.D.* and Kyle Y. Swisher, M.D.*

THE USUAL DEFINITION of cor pulmonale—congestive heart failure secondary to lung disease—begs at least one question: it assumes that the congestion, evidenced by peripheral edema, venous engorgement, and enlargement of the liver, is secondary to decompensation of the right ventricle. This may be an invalid assumption since pathologic studies in patients who die with chronic obstructive pulmonary emphysema and "congestive failure" frequently fail to reveal right ventricular hypertrophy (1).

Dr. Ludwig Eichna has an appealing concept of "congestive failure," which has been summarized recently (2). He separates "congestive failure" into two groups:

A. Congestive *heart* failure.

B. Congestive failure of *noncardiac* origin.

This latter group is subdivided into three categories:

I. Mechanical obstruction to blood flow in and about the heart.

II. Excessive accumulation of water and salts in patients without heart disease.

III. Hyperkinetic circulatory congestion, so-called high output failure.

If one accepts Eichna's concepts and applies them to congestive failure as seen in persons with obstructive emphysema, it seems that the syndrome may well be of noncardiac origin, properly belonging in Group B.

Obstructive emphysema, the lung disease most frequently associated with cor pulmonale, certainly tends to impose the obstruction of Category I, because the pulmonary vascular bed is so frequently reduced in this disease (3). There is also another more subtle mechanism at work: adaptation to increased work of breathing (4) plus the arterial hypoxia and CO_2 retention that are so frequently associated with obstructive airway disease.

We propose that these influences acting alone, without decompensation of the right ventricle, can produce the clinical picture of *congestive failure of respiratory origin* in persons with obstructive emphysema.

By the time patients with obstructive emphysema consult a physician, the disease process has usually progressed to the point where arterial O_2 is reduced and CO_2 retention has developed. If the O_2 requirement, as well as CO_2 production, is increased, as must happen with even mild exertion, adaptive mechanisms will tend to meet the situation by increasing the cardiac output as well as the arterial-venous O_2 and CO_2 differences (5). However, since there is an impediment to pulmonary blood flow imposed by the reduced pulmonary vascular bed, the cardiac output will be less than optimal. Nevertheless, the tissues will continue to extract O_2 and give up CO_2 as required by their metabolic requirements. The result is inevitable: an abnormally low mixed venous O_2, reflecting tissue hypoxia, and an abnormally high mixed venous CO_2, which cannot be lowered economically.

*University of Maryland School of Medicine, Baltimore, Maryland.

With obstructive airway disease, it is *bad economy* to increase respiration enough to blow off the excess CO_2 because the metabolic CO_2 produced thereby can easily exceed the amount excreted (4). Since the CO_2 transport is almost as dependent on hemoglobin as oxygen is, there is "less room" in the blood for O_2 transport from the lungs; thus, there is additional reason for reduced arterial O_2. Reduced arterial O_2, combined with a less than optimal cardiac output, results in reduced O_2 transport (cardiac output multiplied by arterial O_2 content). Tissue hypoxia must now result from mild exertion.

One of many sequelae of tissue hypoxia is increased lactic acid production. This plus the already elevated blood CO_2 content and tension, will increase the blood PCO_2 even more. Here, the kidney enters the picture and reacts to the increased PCO_2 by increasing its resorption of bicarbonate (6). In a normal individual, such an acidosis can be compensated with ease simply by hyperventilating; however, in a person with reduced ventilatory capacity, hyperventilation is no longer an effective mechanism for handling the hydrogen ions produced by the lactic acid accumulation; hence, almost all neutrality regulation must be done by the kidney, which will resorb sodium ion in association with bicarbonate ion in order to excrete hydrogen ion. Since sodium resorption must be accompanied by water retention, the clinical picture of congestive failure with venous congestion, hepatomegaly, and peripheral edema must result.

The right ventricle per se need not be implicated; it may only be in the middle of a vicious cycle and not necessarily "decompensated." Studies made several weeks or months after clearing of congestive failure in persons with cor pulmonale demonstrate a remarkable finding: the cardiac output is much less than during the episode of congestion (5). It is difficult to believe that the congestive failure was cardiac in origin if the right ventricular output was greater during the period of "decompensation" than after the congestive failure had cleared. This is certainly not to say that the heart is not involved; it is involved just as much as if cardiac function were altered by coarctation of the aorta or because constrictive pericarditis restricted cardiac filling.

REFERENCES

1. Harvey, R. and Ferrer, M. Circulation, **21**:236, 1960.
2. Eichna, L. W.: Cardiac Function in Congestive Heart Failure in Man. Work and the Heart, 1959, Paul B. Hoeber, Inc.
3. Shepard, R. H. et al: Am. Rev. Tbc. and Pul. Dis., **71**:2, 1955.
4. Riley, R. L.: Ann. Int. Med. 41:172, 1954.
5. Ferrer, M. I. et al: Circulation, **1**:2, 1950.
6. Brazeau, P. and Gilman, A.: Federation Proc., **12**:19, 1953, Am. J. Physiol., **175**:33, 1953.

NEW CANCER DETECTION FILM

A 16 mm. black and white sound movie entitled "The Cancer Detection Examination" is available for viewing by qualified professional groups. It is being offered as a free service to the medical profession by Eli Lilly and Company.

The film, produced from a video tape of a closed-circuit telecast in cooperation with the American Cancer Society, New Jersey Division, Inc., demonstrates the presymptomatic detection of cancer through simple office procedures. The procedures are demonstrated by Emerson Day, M.D., director of the Strang Clinic, Memorial Center for Cancer and Allied Diseases, New York City, and are those which are basically used at the clinic in approximately 25,000 examinations each year. Showing time is 46 minutes.

An illustrated handbook is available for distribution to viewers of the film. The handbook outlines in detail the procedures shown and provides a ready reference for the physician.

Interested groups of physicians should arrange for booking of the film at least one month in advance. Further information may be obtained from any Lilly salesman.

BALTIMORE CITY HEALTH DEPARTMENT

HUNTINGTON WILLIAMS, M.D.
COMMISSIONER

P. O. Box 1877 Baltimore 3, Md. Plaza 2-2000: Extension 307

Learn To Do Your Part In The Prevention Of Disease

Now The New 4 In 1 Vaccine

In his *Saturday Letter to the Mayor* on April 8, the Commissioner of Health wrote on the prevention of paralytic poliomyelitis as follows:

"May I thank you for your willingness to issue a Proclamation today related to April 12 being recognized as National Poliomyelitis Vaccination Day. Senator George L. Radcliffe, Chairman of the Maryland Chapters of the National Foundation and I are much interested in a more widespread use of polio vaccine in Baltimore at this season, and especially for all preschool age children.

"You will be especially pleased to learn that on Wednesday of this week the new *4 in 1 Vaccine,* became available and was used for the first time in our City Health Department work. I personally inoculated a two month East Baltimore baby with the first dose in the well baby clinic in our Eastern Health District building. We have been waiting eagerly for this new *4 in 1 Vaccine,* as we call it, for it combines in one dose the protective materials against diphtheria, tetanus, whooping cough, and poliomyelitis. This reduces the number of preventive inoculations needed for all Baltimore infants from eight separate injections to four during the first two years of life. It is a great saving indeed. The new *4 in 1 Vaccine* has been extensively tested and has been proven to be as effective as if each part were given separately. It has been approved by the U. S. Public Health Service."

Huntington Williams, M.D.

Commissioner of Health

THE WORLD MEDICAL ASSOCIATION

Fourteenth General Assembly

The German Medical Association will be host to the Fourteenth General Assembly of The World Medical Association in Berlin, September 15-22, 1960. The host organization has scheduled its own annual meeting coincident with the General Assembly, and the opening and closing plenary sessions of both organizations will be held together. All meetings and other activities of both groups will be held in the new Berlin Convention Hall, thus facilitating attendance at whichever sessions are of most interest to individual doctors.

An international film program, the theme of which is "Postgraduate Education," is scheduled during the entire period. The annual dinner, on September 19, will be held at the world famous "Palais am Funkturm." On the final day, September 22, an excursion is planned to include a sight-seeing tour through the East Sector of Berlin and to end with a cruise on Havel Lake.

MAIL-ORDER PRESCRIPTION SCHEMES

IT MAY BE A LONG time before the patient who just walked out of your office with an important prescription in his pocket ever gets around to taking the needed medication; the reason: mail-order prescription schemes. Now being heavily promoted across the nation, such schemes center their publicity on cut-rate prescription prices.

Here, for example, is what might happen to your patient:

Instead of taking his prescription to his community pharmacist to be filled that day, he drops it into the mail to one of these operations, perhaps a thousand miles away. The filled prescription comes back seven to ten days later, often too late to do the job for which it was originally intended. Your patient, in the meantime, still experiencing the symptoms which prompted his visit to you, attempts to tide himself over until the prescription arrives by applying some sort of self-medication which may give him temporary relief and, at the same time, lessen his understanding of the importance of your diagnosis and the drugs you prescribed.

Not only are dangerous delays characteristic of the mail-order mechanism, but also the public is denied the complete services it has a right to expect from any pharmacist in any pharmacy. As a regular practice, mail-order operators refuse prescriptions containing narcotic drugs. Most patients have no knowledge of what is or is not a narcotic drug; therefore, any warnings by the mail-order house that it will not accept prescriptions for narcotic drugs become meaningless. The patient, after exposure to unnecessary delay, discovers that his prescription is only obtainable from his community pharmacy.

Prescriptions for narcotics are not the only ones which mail-order houses refuse to dispense. There are classes of prescriptions which are being refused by mail-order operators for their own convenience, especially prescriptions which require compounding. Both the ethics and traditions of the pharmaceutical profession demand that a pharmacist make every effort possible to promptly dispense every prescription he receives, regardless of the amount of professional attention required.

Because these depots operate on an impersonal assembly-line basis in a jurisdiction where only the supervision (rather than the actual dispensing) by pharmacists is required, the danger of dispensing errors is increased. Moreover, by operating outside the states in which the prescription was originally written, these houses deny the patient the protection he has a right to expect from his own state laws governing the practice of pharmacy.

Another area in which the public is being misled is illustrated by quoting from a full-page advertisement which a District of Columbia mail-order operator inserted in *The Philadelphia Inquirer* of Sunday, April 3, 1960:

> *YOUR PRESCRIPTIONS ARE COMPOUNDED BY REGISTERED PHARMACISTS!*
>
> *Our registered pharmacists compound your prescriptions in ultra-modern, regularly inspected pharmacies—using the finest, freshest nationally known ingredients.*
>
> *YOUR ORDER IS FILLED IMMEDIATELY TO ASSURE YOU OF FRESHNESS!*
>
> *The same day we receive your prescriptions—our pharmacists fill them and mail them out. This assures you of the freshness of every medicine you receive from us. And, of course, with our volume business and volume turnover, our shelves of vitamins and chemical ingredients are constantly replenished with fresh items.*

After publication of this advertisement, it was revealed that the premises described consisted of nothing more than an empty room without any inventory, fixtures, or pharmaceutical equipment. The advertisement was refused by two other large circulation newspapers, and the matter has been called to the attention of the Federal Trade Commission.

Perhaps as important to the medical profession as any other fact is that such schemes make it convenient for certain kinds of practitioners who are unauthorized to prescribe in their own states to write prescriptions that will be filled by these distant operations. The geographical separation between prescriber and dispenser makes it virtually impossible and impractical for these operators to check the source or to offer professional advice to the patient when he receives his medication.

The greatest opportunity for mail-order promotion has been in the geriatric market, where public attention has been mostly concentrated in recent months.

A host of other unanswered questions come to mind when prescriptions are ordered from these assembly-line outfits; for example: How can we safely assume that long-distance dispensing will be as the prescriber intended? Is the way paved for substitution? Has the prescription been compounded under sanitary conditions?

The District of Columbia, where standards for pharmaceutical practice are based on an antiquated 1906 act of Congress, has become the haven for mail-order operators. One of these Washington-based firms was recently brought before Corporation Counsel of the District of Columbia. The investigating officer described the premises as "without facilities for compounding prescriptions" and noted further that the only "sink was located in the rear of the store by going through a room that had waste paper for wrapping and packaging all over the place and the room where the sink was located proved to be filthy and the sink itself was corroded and stained and in a filthy condition."

That these mail-order prescription schemes are truly a menace to public health was emphasized by George M. Fister, M.D., a member of the American Medical Association Board of Trustees, in an address to the recent meeting of the American Pharmaceutical Association House of Delegates. Physicians, he asserted, can easily warn their patients of the many flaws in these dangerous mail-order operations; the mail-order schemes he condemned as "one of the gravest problems" facing the health field today. A physician for more than 30 years, Dr. Fister said that he does his best to discourage any patient from sending prescriptions to a mail-order operation. "The personal touch is still essential," he declared; America's high standard of medical care was "founded on this firm foundation of personal service, and we would be foolish indeed not to preserve it."

The development of highly concentrated synthetic drugs, purified natural products, potent dosage forms, and special needs in storage and dispensing have created new problems of drug supervision, regulation, and administration. The pharmacy and drug laws of each state are designed to protect citizens from the effects of ignorance and incompetency in these matters which are beyond individual patient control.

The American Pharmaceutical Association has launched an educational campaign to inform all members of the medical profession about the inherent dangers in mail-order prescription operations. The national professional society is also supporting H.R. 10597, which will bring to the District of Columbia a modern pharmacy act.

At an emergency meeting in Washington, D. C., haven of the prescription-by-mail operators, Dr. William S. Apple, American Pharmaceutical Association secretary, cautioned: "If this personal pharmacist-patient relationship is not preserved, the next break in the chain will inevitably be the elimination of the physician as the diagnostician and substitution of the mail-order purveyor as the prescriber. The only call on the physician will be to write the death certificate. Individual acceptance of professional responsibility by all members of the medical team can quickly put an end to the development of centralized mail-order prescription depots."

If mail-order prescription hazards are to be fully recognized, the medical profession must join with other members of the health team by reacting quickly and in a positive manner. Otherwise the public will be misled into believing that an impersonal centralized mail-order method is an acceptable substitute for sound community medical-pharmaceutical service.

Book Reviews

Tabulating Equipment and Army Medical Statistics, Brig. Gen. Albert G. Love, USA (Ret.), Col. Eugene L. Hamilton, MSC, USAR, and Ida Levin Hellman, M.Sc., Washington, D. C., Department of the Army, 1958.

This monograph is a historical account of one of the most complete statistical systems in the world. It will be of particular interest to physicians who are interested in biostatics and research, as well as to the group concerned with data-processing equipment.

●

Heritable Disorders of Connective Tissue, ed. 2, Victor A. McKusick, M.D., St. Louis, The C. V. Mosby Company, 1960.

The second edition of this book attests to an increased general interest in genetic disorders as well as in disease of connective tissue. The first edition was a limited publication based on a series of articles from the *Journal of Chronic Diseases.* Clinical experience and investigations in the hereditary disorders of connective tissue have been considerably extended since it appeared. This second edition contains more than 80 illustrations, and 130 pages have been added to round out the clinical and pathologic descriptions.

Dr. McKusick has used a systematic approach to his presentation, including reports on many patients he has seen personally. He focuses attention on those heritable diseases which represent abnormality of a single element or biochemical mechanism of connective tissue wherever it is found throughout the body. Interspersed with arresting historical notes ("Ivar the Boneless," p. 178), the book discusses thoroughly five conditions in particular: the Marfan Syndrome, the Ehlers-Danlos Syndrome, the Hurler Syndrome, Osteogenesis Imperfecta, and Pseudoxanthoma Elasticum, all of which fulfill the author's criteria for inherited diseases of connective tissue.

Beginning with a reasonably concise discussion of the clinical behavior of hereditary syndromes and the biology of normal connective tissue, Dr. McKusick traces the five established conditions with clearness and some humor. He succeeds in synthesizing much scattered information from widespread sources.

A comprehensive bibliography is at the end of each chapter, and a useful index completes the volume, which should be a valuable addition to the library of internists, pediatricians, and general practitioners, in particular, as they are the ones who usually first detect these conditions. It is well recommended as profitable reading for medical students and "pure scientists," too.

Conrad Berens Acton, M.D.

●

Communicable and Infectious Diseases, ed. 4, Franklin H. Top, M.D., et al, St. Louis, The C. V. Mosby Co., 1960.

Many remarkable changes have occurred, particularly in the field of the viral diseases, where several new groups of viruses have been discovered. Some of the common communicable diseases have changed little in occurrence or severity, whereas others are now less common and are milder in manifestation from both the individual and the group point of view. This edition brings completely up to date the previous editions of this work.

●

Neurosurgery, Volume II, History of the Medical Department, U. S. Army, World War II, Department of the Army.

As with Volume I, this book has been edited by two distinguished neurosurgeons, R. Glen Spurling, M.D., professor of neurosurgery at the University of Louisville School of Medicine (formerly senior consultant in neurosurgery in the European Theater of Operations) and Barnes Woodhall, M.D., professor and chairman of the Division of Neurosurgery at Duke University School of Medicine (formerly chief of neurosurgery at Walter Reed General Hospital). In addition to their own contributions, the editors have been supported by 18 other authors, all of whom are outstanding authorities in their specialized fields.

This volume contains a wealth of clinical information which is useful today in peacetime neurosurgery. Numerous illustrations, colored plates, tables, and a comprehensive index are included. It may be purchased from the Superintendent of Documents, Washington 25, D. C., for $7.00 per copy.

●

Anatomy: A Regional Study of Human Structure, Ernest Gardner, M.D., Donald J. Gray, Ph.D., Ronan O'Rahilly, M.Sc., M.D., Philadelphia and London, W. B. Saunders Company, 1960.

The major aims of this work are to provide a textbook that is sufficiently brief for the undergraduate medical and dental student during the present shortened course in human anatomy, to provide information on living anatomy with stress on the importance of the relationship between structure and function and to meet the needs of the more advanced student and the postgraduate worker. The authors have achieved these purposes exceedingly well.

●

Current Therapy, 1960, edited by Howard F. Conn, M.D., Philadelphia and London, W. B. Saunders Company, 1960.

The physician's need for authoritative, detailed, and unbiased information regarding the most effective therapeutic agents, their proper dosage and administration, side effects, and the expected response of the patient is met in this annual publication. The 1960 edition is completely up to date and constitutes a new edition rather than a revision of the old.

Transactions of the Sixth Annual Meeting of the Intersociety Cytology Council.

The Council is a nonprofit organization, and its paperback publication provides the physician with the most up to date information in the field of cytology. This is a handy reference book, useful in any medical library.

●

Preventive Medicine: The Principles of Prevention in the Occurrence and Progression of Disease, edited by Herman E. Hilleboe, M.D., and Granville W. Larimore, M.D., Philadelphia and London, W. B. Saunders Company, 1959.

The material in this book comes from lectures, seminars, and articles by experts in preventive medicine and public health. The main purpose of the material is to outline a practical guide to physicians who are willing to incorporate preventive medicine as an integral part of their day to day practice in the office, in the hospital, in the home, and in the community where they live. Physicians who do so are more than members of the medical profession; they are specialists in community well being, to whom the oath of Hippocrates means a way of life more than just a way of earning a living.

●

Trauma, Harrison L. McLaughlin, M.D., Philadelphia and London, W. B. Saunders Company, 1959.

The first section of the book is devoted to a consideration of the local, regional, and systematic responses to injury, an enunciation of established principles in the treatment of trauma, and discussions of the problems of thermal and vascular trauma and of infection. The later chapters are limited mainly to a rationalization of treatment predicated upon a reconciliation of these fundamentals with the characteristic features, and effects of specific injuries.

●

That the Patient May Know, Harry F. Dowling, M.D., Sc.D., Tom Jones, B.F.A., assisted by Virginia Samter, Philadelphia and London, W. B. Saunders Company, 1959.

This is a most comprehensive manual that shows by illustration how the patient can adequately care for himself and aids him in understanding the various diseases or operations of the human body. It is an excellent text for use in the office to assist the practicing physician in explaining to his patients what steps are necessary for the protection of the patient's health.

●

Christopher's Minor Surgery, Alton Oschner, M.D., and Michael E. DeBakey, M.D., Philadelphia and London, W. B. Saunders Company, 1959.

The busy practitioner, the house officer on an outpatient service and the medical student need for quick reference a text dealing with diagnosis and treatment of surgical disorders that do not require hospitalization. This is an excellent text that should be in every physician's personal reference library.

An Atlas of Normal Radiographic Anatomy, Isadore Meschan, M.A., M.D., Philadelphia and London, W. B. Saunders Company, 1959.

This is not an encyclopedic reference, but rather a practical, useful text for medical students, general practitioners, and residents, as well as for x-ray technicians. It has been extensively revised and brought up to date. It is a reference that any physician who performs extensive x-ray work should have at hand.

●

Biopsy Manual, James D. Hardy, M.D., James C. Griffin, Jr., M.D., and Jorge A. Rodriguez, M.D., Philadelphia and London, W. B. Saunders Company, 1959.

This book brings together, in a convenient handbook, a distillation of the experiences of the authors and others. While this is a book of only 150 pages, it contains excellent information for the avid reader.

●

Textbook of Pediatrics, Waldo E. Nelson, M.D., Philadelphia and London, W. B. Saunders Company, 1959.

This is the seventh edition of this book, and the revisions, including several completely new chapters, bring it completely up to date. The contributors include some of the most distinguished workers in their fields. This edition truly serves both students and practitioners in their search for a better understanding of the medical problems of infants and children.

●

Dr. Kelly of Hopkins, Audrey W. Davis, Baltimore, The Johns Hopkins Press, 1959.

This is the first full biography of Howard A. Kelly, M.D., the brilliant surgeon and gynecologist who, along with Drs. Welch, Osler, and Halsted, inaugurated the Johns Hopkins Hospital and worked to establish the School of Medicine of the Johns Hopkins University. The book is the result of much work by the author, who was left a wealth of material by Dr. Kelly, who had asked her to write his biography.

●

Elementary Statistics, New York, Dover Publications, 1959.

This book deals with elementary statistical methods, and it should be useful to workers in medical and allied fields. It is worth having for reference purposes.

●

Aids to Arithmetic in Nursing, Bailliere, Tindall and Cox, Baltimore, Williams and Wilkins Company, 1959.

Here is a simple textbook that should be helpful to the nursing student and the graduate nurse who is having difficulty with her mathematics. As a reference or training aid it is invaluable.

M. Ruth Moubray, R.N.

Executive Secretary

ANA Statement On Practices Relating to Nurses From Abroad

As THE PROFESSIONAL organization for registered nurses in this country, the United States member of the International Council of Nurses, and an official sponsor of the Department of State's Exchange-Visitor Program for Nurses, the American Nurses' Association is concerned about practices relating to foreign nurses in this country under the Exchange-Visitor Program or on immigration visas.

The ANA strongly commends and supports the purposes and objectives of the Exchange-Visitor Program as outlined in the Information and Education Act of 1948. The basic aim of the Exchange-Visitor Program for Nurses is to afford educational experiences for nurses, in order to help them improve their knowledge and skills, which will be useful to them when they return to their own countries, and thereby promote better understanding of the United States.

Aware of the values of this program, the ANA recognizes the need to safeguard its purposes and objectives and, at the same time, to protect the practice of nursing in the interests of the public.

Many complaints about abuses of the Exchange-Visitor Program for Nurses have come to the attention of the American Nurses' Association. Among such abuses reported are: misleading advertisements which promise but do not fulfill planned educational experience for foreign nurses; inadequately supervised programs; utilization of foreign nurses to help meet the service needs of the institution, leading to unsafe practice; payment to foreign nurses of low stipends, tending to lower the economic status of United States nurses. Such practices, representing deviation from the original intent of the Exchange-Visitor Program, lead to serious consequences. This is especially true when the program is used as an employment instrument rather than an educational program. It can lead to disappointment and frustration for nurses who come to this country to improve their knowledge and skills and can impair our country's international relationships. It endangers the safe care of patients. It unfairly affects the professional and economic status of nurses in the United States.

The ANA is equally concerned with the recruitment of foreign nurses under immigration visas for the express purpose of their employment in this country, without adequate regard for licensing requirements or for their qualifications to carry out the functions they are called on to perform.

The ANA recognizes as acceptable practice the employment of graduate nurses who wish voluntarily to immigrate to the United States, provided they have adequate educational preparation for the functions they are expected to discharge, are able to meet the licensing requirements for registration in a state, and possess a sufficient command of English to permit them to practice safely.

In view of the shortage of nursing personnel the world over, the ANA opposes the active recruiting, by advertisements or other inducements, of nurses from countries which are critically short of nurses. The ANA likewise condemns the practice of employing as subsidiary workers nurses who cannot meet licensing requirements. This practice is especially dangerous if such personnel are assigned responsibilities which should be restricted to qualified graduate nurses. Such employment practices not only run counter to accepted international professional concepts of good nursing education and practice, but jeopardize the safe care of patients in the United States.

The American Nurses' Association, therefore, goes on record as commending the purposes and objectives of the Exchange-Visitor Program and approving the legitimate employment of nurses in this country under immigration visas, provided they meet requirements for licensure, but as deploring abuses of the Exchange-Visitor Program leading to corruption of the original intent of the program and to unsafe nursing practice and the indiscriminate recruitment of nurses from other countries for the purpose of their employment as nurses in the United States.

THE WOMAN'S AUXILIARY IN 1959

Highlights of the report of the retiring president, Mrs. D. Delmas Caples. The complete report was presented at the eleventh annual convention of the Woman's Auxiliary to the Medical and Chirurgical Faculty of Maryland

MRS. CAPLES VISITED the eight organized components and either addressed them or installed their officers. She attended the national convention in Atlantic City and the conference of presidents and presidents-elect in Chicago, served on panels at each of these meetings, presided at five board meetings, including a conference during the Ocean City meeting of the Medical and Chirurgical Faculty, and visited neighboring state auxiliaries. As president, Mrs. Caples conferred with the executive secretary of the Faculty and his assistant on ways in which the Woman's Auxiliary and the Faculty might be of greater assistance to each other.

Through various fund-raising projects of the components, the following sums were contributed to the American Medical Education Foundation: Baltimore City, $714.43; Baltimore County, $185.76; Carroll County, $89.00; Montgomery County, $105.00; Prince George's County, $25.00; Washington County, $69.95. The total contribution was $1,189.14.

Community service was accomplished by cooperation with various other community groups, educational programs for the public, film loans, aid to medical students, and animal loans to schools.

The mental health chairman reported that good clean clothes, books, and magazines were collected for patients ready to leave the hospitals. Speakers on mental health topics were obtained for two county meetings, and members of the various components contributed presents and services to mental institutions.

Aiding the medical profession in its fight against the Forand Bill, the Legislative Committee sent out pamphlets, which were distributed to civic organizations, wrote letters to congressmen, and sent a resolution opposing the Forand Bill to all congressmen. The Auxiliary's legislative activities also included letters to congressmen favoring the Keough-Simpson Bill, attendance at the six State Conferences on Aging, participation in Project #60, and efforts on behalf of traffic safety laws.

Doctor's Day was observed March 30 by each component auxiliary. Carroll County had an exhibit in the county library of old and new medical instruments used by the doctors in that county and old diplomas. Prince George's County held a buffet luncheon. Washington County held a buffet supper for the doctors and featured in the newspaper an article of a father and son doctor team in their county. Montgomery County held a cocktail party, and Caroline County had published in the newspaper a copy of the Governor's Proclamation and a story of Nathaniel Potter, M.D., a native of that county, who was the first teacher of medicine at the University of Maryland Medical School. Baltimore City honored their doctors by contributing $50.00 to the American Medical Education Foundation. All components gave their doctors red carnations or placed the flowers in hospitals in memory of deceased physicians.

New auxiliaries were formed in Allegany-Garrett Counties and Harford County. Doctors' wives in unorganized counties were reminded by letter of the contributions they can make to their

husbands' profession by becoming members-at-large. There are now 54 members-at-large and 851 members of the eight component auxiliaries.

Home preparedness and family preparedness were stressed by the Civil Defense Committee, and all but one county auxiliary had a special meeting on home preparedness, at which kits were distributed. Mrs. Charles Williams, a member of the Steering Committee, Region #2, Women's Civil Defense, representing the AMA Auxiliary, attended a three-day conference in Washington and represented the Maryland Auxiliary at an all day meeting on the new statewide Civil Defense Home Preparedness Awards program. The chairman worked closely with the director and personnel at the State Civil Defense headquarters.

Films on safety were supplied to various women's groups, and the Auxiliary was represented at the Home Safety Show in Baltimore last fall. Several legislative measures pertaining to safety were endorsed by the Woman's Auxiliary and have become law. Safety chairman, Mrs. Stuart Sunday, attended the fourth annual teenage youth conference at Johns Hopkins University, sponsored by the Baltimore Safety Council and the *Sunpapers* to promote traffic safety. A number of articles and pamphlets on various aspects of safety are available on request.

Members of the Auxiliary have continued to work closely with the Future Nurse Clubs throughout the state, and representatives attended the various meetings. A Maryland club received the first National Charter of a Future Nurse Club. Most auxiliaries have scholarships available to students pursuing a health career, and Baltimore City has a student aid fund for such a purpose.

Meet The Presidents

Born and raised in Bridgeport, Connecticut, Jean Lewis attended and graduated from Saint Vincent's Hospital School of Nursing. It was there she met her husband, Thomas F. Lewis, M.D., who was interning at the time. They were married in June, 1951. When Doctor Lewis completed his residency in general surgery, they settled in Cumberland, Maryland. They now have three sons and expect a fourth child by the time of this publication.

Jean Lewis has been active in the Ladies' Auxiliary to the Memorial Hospital and was among those helping to organize the Woman's Auxiliary to the Allegany-Garrett County Medical Society.

Allegany-Garrett Auxiliary's Health Panel

The Committee on Public Medical Education has been conducting a series of panel discussions entitled "Changes in Trends in Medicine." The purpose of this panel has been to promote a better understanding between the community and its health professions. The panel usually has five or six members consisting of a general practitioner, a surgeon, a dentist, a pharmacist, and a hospital administrator. Each member is invited to briefly discuss current trends and advances in his field and its effect on the community. It is the duty of the moderator to keep

the discussion practical and impersonal and to allow sufficient time for queries from the audience.

Presentation of the first panel discussion left no doubt that this was a worthwhile project. The maze of medical lingo hurled at the public today, through every medium possible, often leads to a blurring of the mind rather than a true conception of the facts. Here, then, is the true value of our project: an opportunity for better understanding with the public through a down to earth approach.

The question and answer period proved to be the most successful portion of the program. Questions ranged from the high cost of antibiotics, safety of fluoridation, vaccination techniques, hospital practices and procedures, to the education and training of doctors.

Thanks go to Carlton Brinsfield, M.D., surgeon and moderator; George Simons, M.D., and Dr. William Iames, M.D., medical participants; Dr. Warren Cook, Dr. Richard Bolyard and Dr. Norman Barger, dentists; Mr. E. R. Kellough, Jr., pharmacist; and Mr. John Moberly, administrator of Memorial Hospital.

Mrs. Carlton Brinsfield
Chairman

CALENDAR OF EVENTS

► Wednesday, June 22 ◄

UNION MEMORIAL HOSPITAL
5:00 P.M. Hall 2 Conference Room
SURGICAL STAFF
Moses Paulson, M.D., and Mark M. Ravitch, M.D.,
"Ulcerative Colitis."

► Tuesday, June 28 ◄

BALTIMORE CITY DENTAL SOCIETY
Annual outing—Rolling Road Golf Club

► Tuesday, July 12 ◄

MARYLAND SOCIETY ON ALCOHOLISM
Officers and Executive Committee
8:00 P.M. Council of Social Agencies, 22 Light Street

► Wednesday, July 13 ◄

MARYLAND SOCIETY FOR
MENTALLY RETARDED CHILDREN
GREATER BALTIMORE CHAPTER
8:15 P.M., 2525 Kirk Avenue

CITY OF HOPE APPOINTS DR. BESSMAN

Appointment of Dr. Alice Bessman, 1708 Roslyn Ave., Baltimore, as local medical representative for the City of Hope National Medical Center, Duarte, California, was announced by Dr. Paul L. Wermer, executive medical director. Dr. Bessman is authorized to act as liaison between physicians in this area and the City of Hope, which accepts only on proper medical referral, medically and economically eligible patients with neoplastic, cardiac, hematologic, thoracic, and certain hereditary diseases.

The City of Hope, near Los Angeles, is a free and nonsectarian medical and research center.